AN INVESTIGATION OF CULTURAL COMPETENCY IN THE EXPERIENCES OF THERAPISTS NEWLY TRAINED TO DELIVER COGNITIVE-BEHAVIOURAL THERAPY

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Abstract

Background: Policies and guidance on the provision of mental health services to the diverse UK population acknowledge the need for therapists to be able to deliver psychological interventions in a culturally sensitive way to meet the needs of Black and Minority Ethnic groups. The requirements are highly relevant to Cognitive-Behavioural Therapists employed under the national Improving Access to Psychological Therapies programme which was introduced to address common mental health problems.

Research rationale: Literature contains a wealth of material relevant to the cultural competency required of psychological practitioners, however writers have tended to focus on different facets of competency. A framework based on the guidance dispersed throughout the literature would serve as useful tool to investigate whether therapists emerging from IAPT training work in a way that is consistent with cultural competency practice guidance. A study could also explore how cultural competency, if evident, is acquired and how training contributes.

Method: A narrative review of the literature was conducted to generate a thematic template that could be contrasted with the views and practices of therapists who had recently undergone IAPT training. Focus group interviews were conducted with participants at three IAPT services and the captured data was thematically analysed using Template Analysis whereby the themes from the review could be incorporated into the template used for the analysis.

Findings: Participants demonstrated a range of perspectives and practices that were consistent with cultural competency guidance in the literature. Abilities were attributed to personal and professional experience, and to personal motivation to develop the capacity to work sensitively. Training was not considered to have significantly contributed to cultural competency and suggestions for how it may be improved were presented. It was concluded that it was possible for therapists to work in a culturally sensitive way without a comprehensive training based on cultural competency guidance, but that improvements for training could be drawn from the study.

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Culturally Competent Practitioners in Mental Health.

A Review of the Requirements

1. Abstract

Cultural competency in the context of health services pertains to the appropriate provision of care to a diverse population. It is broadly recognised that this requires sensitivity at policy-making, organisational and individual levels. One specific focus in the literature has been the aptitudes required of practitioners to carry out psychological interventions with members of minority ethnic groups. A range of theoretical and practical perspectives have emerged on what such aptitudes should be and how to attain them. However, lack of clarity over definitions has resulted in a differential focus on sub-components of the cultural competency construct, namely awareness, knowledge and skills. The current review aimed to consolidate material dispersed across the literature, in order to create a narrative representation of what cultural competence means to the clinical practice of individuals delivering psychotherapeutic interventions. Limitations and implications of the cultural competency approach are discussed.

2. Introduction

'Cultural competency' refers to a range of theoretical perspectives and practical guidance on providing health care that meets the needs of a population diverse in gender, race, ethnicity, sexual orientation, age, religion, [dis]ability, language, national origin, immigration status and socioeconomic status. Department of Health (DoH) papers such as *Inside/Outside* (2003), *Delivering Race Equality: A Framework for Action* (2003) and *The Single Equality Scheme* (2009) endorse the cultural competency ethos as essential to eradication of inequalities in mental health.

> Cross, Brazen, Dennis, and Isaacs (1989) defined cultural competence as:
>
> "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations. The word "culture" is used because it implies the integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively."
>
> (1989, p. 13)

The UK mental health sector acknowledges that equitable service provision for a diverse population requires cultural competence at policy-making, organisational and individual levels (Bennett, Kalathil, & Keating, 2007; Bhui & Bhugra, 2007; DoH, 2003; Hall, Iwamasa, & Smith, 2003).

2.1 Cultural competency in clinical practice

There is wealth of literature on what cultural competency means at the level of individual clinical practice. Some approaches have focused on specific disciplines, e.g.

Nursing, Counselling, Social Work (see for reviews Balcazar, Suarez-Balcazar, Taylor-Ritzler, & Keys, 2010; Mollen, Ridley, & Hill, 2003). Application of cultural competence to psychotherapeutic interventions has arguably warranted a more complex approach. Bernal and Scharron-Del-Rio, (2001) highlight that psychotherapy is itself a cultural phenomenon that plays a key role in treatment process.

Sue, Arredondo, and McDavis (1992) argue that although culture can be broadly defined to include age, class, religion, race, ethnicity, sexual orientation etc., to limit all cultural competency approaches to such a broad application can serve to neglect the needs of specific cultural groups. So, for example, a cultural competency based on racial and ethnic factors warrants a specific research focus.

Some approaches can be classed as 'categorical', in that they involve knowledge of, and tailored intervention for, a particular cultural group. For example, a range of adaptations of Cognitive-Behavioural Therapy (CBT) have been suggested for different minority groups in the US (see Griner & Smith, 2006; Horrell, 2008). In the UK, Rathod, Kingdon, Phiri, and Gobbi (2010) have progressed development of a CBT manual for certain minority groups.

In recent years cultural competence research has shifted focus from the categorical to approaches that aim to develop a practitioner's competence to work with socio-cultural factors that affect the *individual* (see Betancourt & Green, 2010). The shift was driven by concern over the capacity of categorical approaches to stereotype and assign sets of beliefs, values and/or behaviours to those groups, thereby neglecting within-group differences and the individual context.

Different psychotherapy schools have begun to consider how cultural competence fits with their own theoretical frameworks, however much research has focused on intervention technique (Sue, Zane, Hall, & Berger, 2009). Lago (2006) and Webb Johnson (1993) have suggested that therapeutic modality is not as significant as practitioner

characteristics and aptitude. The idea is not objectionable when one considers the evidence that factors relating to the client (commitment, motivation etc.) and the quality of the therapeutic relationship are the most critical elements to outcome (see Bozarth, 1998). Furthermore, Fuertes et al. (2006) found that practitioners rated highly by ethnic minority clients on therapeutic alliance and empathy were also rated higher in cultural competency.

Perspectives on practitioner cultural competence have emerged from various schools, especially counselling/counselling psychology, most noticeably since since the work of Cross et al. (1989) which proposed a framework for a culturally competent system of care, and Sue, Arredondo, & McDavis (1992) which presented a comprehensive competency framework for counsellors. In response to such contributions the American Psychological Association (APA) produced specific guidance to meet diverse needs (2002; 1993). However, lack of clarity around what cultural competence is still persists, and writers have tended to focus on different aspects (awareness or knowledge or skills) of what is essentially the same construct (D. Sue, 2001). Information of relevance to culturally competent practice is therefore dispersed throughout the literature.

2.2 Application for UK practitioners

The UK mental health sector recognises the need to develop the cultural competence of its workforce and there is much literature to inform the practice of psychotherapy professionals. Research geared towards specific minority groups in other countries is not necessarily exportable to the UK with its own diversity; this type of research is better duplicated in the UK (e.g. Rathod et al., 2010). However, information on practitioner cultural competence can be useful to training institutions for various psychotherapeutic disciplines, e.g. CBT, Counselling, Clinical Psychology, Dynamic Psychotherapy. The information would also have utility in recruitment and ongoing development of

‘Knowledge and Skills Frameworks’ and ‘National Occupational Standards’ for relevant professions.

Given: a) the dispersed literature on various facets of cultural competence; and b) the broad consensus that cultural competence of practitioners is vital, there is merit in consolidating the major theoretical contributions to the area of cultural competence in a narrative review. Each contribution could be examined to identify what elements of practitioner aptitude it proposes and how they are applied. For example, does an article promote self-awareness, and if so how does it delineate self-awareness? Given the case for a specific focus on ethnocultural aspects, the review will limit its scope to this application with the ‘adult’ population. The aim of the current paper is therefore to summarise, from contemporary literature, the aptitudes required of a psychotherapy practitioner so that they can be described as attaining cultural competence. The current review aims to include sufficient perspectives in order that a representative summary of the literature is presented.

3. Method

The Health and Social Sciences databases BNI, CINAHL, EMBASE, PsychINFO, Pubmed, Medline, and Google Scholar, were searched for English language peer-reviewed journal articles, books and reports published between 1985 and 2011. The search terms used were: ‘cultur[e]’ OR ‘multi[-]cultural’ OR ‘cross[-]cultural’ AND ‘competenc[e]’ OR ‘capabilit[y]’ AND ‘therap[y]’ OR ‘counsel[ling]’ OR ‘mental health’ OR ‘best practice’. Two hundred and thirty articles and book chapters were retrieved excluding dissertations, technical reports and conference presentations. Abstracts and chapters were reviewed and exclusions were articles:

- that provided only macro-level information, e.g. institutional, policy-making.
- that focused on practice for health professions in general i.e. was not specifically geared toward psychological intervention.

- that were based on characteristics of a specific ethnic group.
- that focused purely on technical aspects of intervention associated only with a specific therapeutic modality.
- that commented on or reviewed previous work without providing original contribution.

Papers and chapters that met the inclusion criteria numbered 20. Forward and reverse citation tracking was applied to these papers to supply a further 60 papers which provided background information.

The 20 core papers were examined for descriptive and prescriptive components that could be included under the three facets of cultural competency; namely *awareness*, *knowledge*, and *skills*. Each paper was examined for statements and guidance relating to cultural competency. These were organised under the major themes of awareness, knowledge and skills. Once the material had been thus organised, it was re-examined to identify sub-themes within each major theme and the material was clustered according to the emergent sub-themes. Major and minor themes were used as an organising framework to produce a synthesised account of the literature. The core articles and chapters are marked with an asterisk in the references. Appendix 1 gives details of the articles and chapters incorporated in the review.

4. Results

4.1 Awareness

Cross et al. (1989) highlighted that the first step toward cultural competence is to acknowledge that there are culturally influenced differences in how people strive to meet their needs. The practitioner must recognise that to accept and respect differences in

communication, world view, relations, and definitions of health, is critical to successful outcome (Cross et al., 1989; Sue, Arredondo, & McDavis, 1992).

4.1.1 Critical awareness of self.

A number of studies suggest that to work with difference the practitioner must first build awareness of their own culturally influenced perspective (Collins & Arthur, 2007; D. Sue, 2001; Sue, Arredondo, & McDavis, 1992). One needs to appreciate that, as a cultural being, one's worldview is shaped by personal identity factors (e.g. genetics, personality), professional identity factors (e.g. theory, practice, ethics), cultural identity factors (e.g. cultural heritage, social class, ethnic identity, gender, sexual orientation, ability), and contextual factors (e.g. historical context, environment, social norms). Self-scrutiny is a lifelong challenging process associated with growth in competence (Sue, Arredondo, & McDavis, 1992). The practitioner must habitually question their assumptions about behaviour, values, beliefs etc., and consider how the socio-cultural reality of their environment has been constructed (Eleftheriadou, 2002; Lopez, 1997; 2006; Pedersen, 2001).

Judgments are implicit to therapeutic practice and the practitioner must be aware of their capacity to think or act prejudicially (Collins & Arthur, 2007; Ridley, 1995). For example, one might make judgements about body language, and competence involves being aware of the cultural roots of one's assumptions about body language. An individual who is blind to their own capacity to act prejudicially risks inadvertently sustaining inequality (APA, 2003; Pedersen, 1995; Ponterotto & Pedersen, 1993; D. Sue, 2001).

Collins & Arthur (2007) suggest that to consider one's position on values that underpin cultural competence is also important. Practitioners should reflect on how the values of their professional role are (or are not) played out in personal life, and vice versa (Sue, Arredondo, & McDavis, 1992; Toporek & Reza, 2001). A practitioner may endeavour to help a client in an equitable way according to the values of their profession, yet they may

hold personal feelings or views about a cultural group with which the client is associated. The practitioner may need to examine personal reactions to race, sexual orientation, age etc. (Daniels, Roysircar, Abeles, & Boyd, 2004) and the impact of such reactions on their therapeutic role.

A number of writers (Campinha-Bacote, 2002; Sue, Arredondo, & McDavis, 1992) argue that self-scrutiny also involves evaluating one's practice in the light of contemporary research. Toporek and Reza (2001) suggest that a practitioner can assess their own growth in terms of cognitive, affective and behavioural change. Does the practitioner perceive that their beliefs, understandings, assumptions, feelings and behaviours have changed toward others, situations or conditions, in personal, professional and institutional contexts? Cultural competency assessment tools (see Sue, Zane et al., 2009) can be used to evaluate progress and identify areas for development.

4.1.2 Awareness of 'other'.

Identity, as shaped by culture, is complex and contextual. A person cannot be categorised simply as, for example, Black, disabled, gay, or a refugee. A combination of identities can be salient for a person in a given context. Identity is multidimensional and can accommodate factors such as ethnicity, nationality, religion, gender, age, sexual orientation and socioeconomic status (Hays, 2001). To recognise and work with the multiple client identities is a key requirement for practitioners.

Several authors argue that to fully appreciate the multidimensional nature of identity a practitioner must be familiar with cultural identity theory (e.g. APA, 2003; Lago, 2006; Macdougall & Arthur, 2001; Patel, et al., 2000; Sue & Sue, 1990). An appreciation of cultural identity will help the practitioner to respond to both interpersonal and intrapersonal dynamics. Cultural identity refers to "an individual's sense of belonging to a cultural group and the part of one's personality that is attributable to cultural group membership" (Lee, 2006, p. 179). The development of cultural identity influences one's attitude toward

oneself, members of one's cultural group, and members of other cultural groups. Lee (2006) and Daniels et al. (2004) cite a series of developmental models that focus on specific aspects of identity including: racial/ethnic identity (Atkinson et al., 1993; Cross, 1995; Helms, 1995); biracial identity (Kerwin & Ponterotto, 1995; Poston, 1990;) and acculturation (Berry & Kim, 1988); feminist and womanist identity (Downing & Roush, 1985; Ossana et al., 1992); disability identity (Gill, 1987; Vash, 1981); homosexual/gay/lesbian/bisexual identity (Cass, 1979; Coleman, 1982; Marszalek & Cashwell, 1999; McCarn & Fassinger, 1996; Troiden, 1988); and heterosexual identity (Mohr, 2002; Worthington, Bielstein Savoy, Dillon, & Vernaglia, 2002). A practitioner may utilise relevant models to understand how a client's multidimensional identity development is: reflected in their beliefs, values and behaviours; implicated in the problem (APA, 2003), and influencing the therapeutic relationship and process (Macdougall & Arthur, 2001).

Therapy is the meeting of individuals who may identify with a range of groups. Both practitioner and client hold a unique history of relations between their groups. Political and power dynamics will usually have influenced relations between the groups (Slaughter, 1988; as cited in Cross et al., 1989). The practitioner must be aware of potential stereotypes that they and the client may hold, be sensitive to beliefs, attitudes and feelings associated with those stereotypes, and be conscious of their influence in therapy (Cross et al., 1989; S. Sue, 1998). However, each client will vary in their relationship to any group, and should therefore be viewed as culturally unique. The practitioner must determine which group association is relevant through exploration with the client (Collins & Arthur, 2007; Lo & Fung, 2003; S. Sue, 1998; Tseng, 2004).

Cultural competence dictates that a practitioner should not only seek to understand the cultural background of a client, but be able to non-judgmentally accept their beliefs, values, and worldview as legitimate perspectives (APA, 2002; Sue, Arredondo, &

McDavis, 1992). However, they may also determine that a cultural belief is unhealthy or contrary to societal values, and seek to change it (Lo & Fung, 2003). The practitioner should not unnecessarily focus on difference or over-emphasize it (Stuart, 2004). Differences may or may not be appropriate to spotlight as relevant to the client's problem. Sensitivity demands recognition of commonality whilst making enquiries to determine the salience of cultural factors (Lo & Fung, 2003).

4.1.3 Awareness of the social and political context.

A number of studies (DoH, 2003; D. Sue, 2001; Sue, Arredondo, & McDavis, 1992) suggest that a practitioner must recognise the social, economic and political forces that sustain inequity and, as necessary, provide space for the client to express forms of distress arising from discriminatory systems. Society has a tendency to systematically stereotype people on the basis of age, sexuality, race, gender etc., and this tendency can result in discrimination and oppression. The practitioner may need to attend to how the client may have internalized systemic messages (e.g. ageism, homophobia, racism, sexism), and intervention might include the need to recognize and externalize forms of oppression (APA, 2003; Collins & Arthur, 2007; Daniels et al., 2004).

Sue (1998) states that social forces within a community can also influence problem manifestation and help-seeking behaviour. A member of an ethnic minority may struggle with stigma and shame associated with mental health services (Lo & Fung, 2003; Sue & Sue, 1999). Collins & Arthur (2007) highlight that awareness of such issues can sensitize the practitioner to ask exploratory questions that accommodate important cultural factors. However, the practitioner must assess the salience of cultural factors in the context of the individual client and know when a characteristic or issue is unique to the client and when it is typical to a particular group (S. Sue, 1998).

4.2 Knowledge

Lo & Fung (2003) and Campinha-Bacote (2002) suggest that cultural awareness and skills are linked to knowledge of theory and practice relevant to all cross-cultural encounters, and knowledge of the characteristics of specific cultural groups.

Theory and practice relating to the role of culture in therapy is constantly evolving as is population diversity. Cross et al. (1989) state that the practitioner must seek out relevant supplemental knowledge according to the needs of their practice, and know where to look, who to ask, and what to ask. Importantly, the practitioner will appreciate that knowledge of diversity perspectives does not displace theoretical and technical approaches implicit in psychotherapeutic practice. The aim of diversity perspectives is to facilitate core conditions of safety, support, rapport and the relationship, however adjustment may be required to achieve these (APA, 2003; Daniels et al., 2004).

Writers have identified several continuums on which the cultural orientations and values of a community that shares a cultural heritage of non-Western roots can differ from a host Western society. Table 1 shows commonly accepted differences in conceptual orientation and values (Fernando, 1991; Laungani, 1997; Schilling & Brannon, 1986). Laungani (1997) states that orientation features are not dichotomies but rather continuums along which a person's values and behaviours can be situated. 'Acculturation', which refers to the degree of identification with a host culture and a culture of origin, is one process which influences an individual's location on the continuums. Berry & Sam (1996) suggest that stages of acculturation that lead to non-identification with both host culture and heritage culture can result in persons being marginalized and more susceptible to mental health problems. Practitioners can therefore be more effective if they have knowledge of the common contrasting values and orientations, and understand how an individual's well-being is related to their unique stage of psychosocial and acculturative adjustment.

Western cultures	*Eastern cultures*
Orientation	
Control	Acceptance
Personal autonomy	Harmony
Cognitivism	Emotionalism
Understanding by analysis	Understanding by awareness
Problem solving	Contemplation
Body mind distinction	Body-mind-spirit unity
Individualism/privacy	Collectivism / group welfare
Mastery over nature	Harmony with nature
Future orientation	Past or present orientation
Free will	Determinism
Values	
Doing/activity	Being/fate
Time dominates	Personal interaction dominates
Human equality	Hierarchy/rank/status
Self-help	Birthright, inheritance
Competition	Co-operation
Directness/openness/honesty	Respect, restraint
Practicality/efficiency	Idealism
Materialism	Spiritualism
Informality	Formality

Table 1: Orientation differences between Western and Eastern cultures. Adapted from Laungani (1997), Fernando (1991) and Schilling & Brannon (1986).

Knowledge of potential differences in orientation and values enables the practitioner to contextualise a client's comments. This faciliates understanding of culturally influenced worldview, problem conceptualisation, and the description of recovery. For example, Fernando (1991) points out that Western psychological practice inherently incorporates a mind-body distinction. In the West, mental illness is understood as a 'disease' of the mind and expressed in psychological terms, whereas in Eastern oriented cultures it can be seen as an imbalance between mind, body and spirit, and expressed in physical terms (Krause, 1989). Knowledge of such fundamental differences enables the

practitioner to, through exploration, contextualise a client's comments and arrive at an appropriate formulation.

Cultural difference can influence not only orientation, values and mental health/illness concept, but also the perceived solution to a problem. Symptomology consistent with a Western construct of depression has fairly standardised interventions for mental health practitioners (National Institute for Health and Clinical Excellence [NICE], 2009), however Nadirshaw (2009) highlights that 'depression' could be perceived as a predominantly spiritual issue, and require a solution that involves prayer or meditation. The practitioner would need to balance what might be achieved through therapy with client expectation. To achieve therapeutic goals consistent with the needs of the client, the practitioner may benefit from knowledge of a wider range of interventions and resources commonly utilised by the client's cultural community, e.g. group-specific strategies or 'healers' (Coleman & Wampold, 2003, as cited in Collins & Arthur, 2007). To be able to learn about and draw on these resources requires links with the community.

4.2.1 Group-specific knowledge.

Cross, Brazen, Dennis, & Isaacs (1989) stated that a practitioner should acquire knowledge about specific cultural groups they are likely to work with, including knowledge of traditions, history, values, family systems, help-seeking behaviours and communication styles. Nadirshaw (2009) also emphasises the need to build understanding of spiritual/religious beliefs and practices, and health and risk factors specific to a community, as well as common community explanations of 'mental' health problems. Daniels et al. (2004) point out that the process of exploration with a client may itself be experienced by the practitioner as an 'education' in cultural knowledge. The practitioner should not, however, rely solely on the client for information; they should endeavour to accumulate knowledge about relevant cultural groups. Alberta & Wood (2009) argue that knowledge acquisition should be grounded in interactions with cultural groups in routine settings. A

degree of ‘immersion’ in a community will facilitate understanding of a cultural group, and serve to integrate cultural beliefs and terminology into health care practices (APA, 2003; St. Clair & McKenry, 1999). Acquired knowledge should not however be applied indiscriminately so as to overlook individuality (Campinha-Bacote, 2002).

4.3 Skills

Cultural skills involve the ability to apply awareness and knowledge to therapeutic practice, and make culture-centred adjustments (APA, 2003). Such skills are relevant at all stages of the intervention and involve modification of process and contextualisation of content. Key areas that demand such skills were found to be: *communication and language*; *building the therapeutic relationship*; *reaching a shared understanding;* and *intervention strategies and goals*.

4.3.1 Communication and language.

A challenge to communication is introduced when practitioner and client spoken languages differ. The responsibility to recruit a ‘competent’ interpreter (Tribe & Raval, 2003) rests with the practitioner (Sue, Arredondo, & McDavis, 1992). Interpreters influence the communication and processing of information, therefore practitioner should guide the interpreter in their function (Lago, 2006; Patel, et al., 2000; Sue, Arredondo, & McDavis, 1992; Tseng, 2004). This might involve pre and post session discussion to address: the way in which the practitioner will be working; what is required of the interpreter; any concerns or feedback the interpreter may have; feelings triggered for the interpreter (Blackwell, 2005; Patel, et al., 2000).

Lo & Fung (2003) and Cross (1995) suggest that whether using an interpreter or not, the practitioner must consider verbal and non-verbal communication style. One must understand how communication in one’s own language involves implicit judgments and sense-making on the basis of accent, volume, tone, pitch, rhythm, sighs, silences etc., and

how cultural difference affect the interpretive capacity of practitioner and client (Gumperz, Jupp, & Roberts, 1981; Hall, 1976; Lago, 2006).

It has been highlighted that particular attention should be paid to language use in cross-cultural encounters (Leong, 1997; Lo & Fung, 2003). Firstly, there may not be linguistic equivalence across cultures, i.e. practitioner and client may not have the same words for objects, activities or phenomena. Secondly, linguistically equivalent words may evoke different psychological associations, for example, 'love' may hold different meanings in two different languages. A practitioner must discern when to explore what a client means by a given word, and be able to work with, for example, a phenomenon for which they hold no comparable term.

Non-verbal behaviours such as emotional display, gestures, eye contact, or touch can also be culture-bound and hold different meanings in different societies (Hall, 1976). Interpretation of affect and its antecedents is a key part of many psychotherapy modalities. The practitioner must consider how a client's culture influences the display (or non-display) of emotional expression, and consider what personal and cultural group meanings are associated with an expression (Lo & Fung, 2003).

4.3.2 Building the therapeutic relationship.

A number of studies suggest that a key factor in therapeutic success is the quality of the working relationship (Coleman & Wampold, 2003; Fischer et al., 1998; Roysircar, Hubbell, & Gard, 2003; as cited in Collins & Arthur, 2007). To establish a good relationship across cultures may require technical adjustments to communication and intervention style (Sue, Arredondo, & McDavis, 1992; Sue & Torino, 2005).

Sue and Zane (1987) state that practitioner *credibility* significantly influences the client's motivation to engage in therapy and their expectations for success. To establish credibility requires attention to how the client's expectations are influenced by cultural norms and identities. Tseng (2004) highlights that societies have their own understandings

of an appropriate relationship between ‘superior’ and ‘subordinate’. A client may expect a practitioner to act authoritatively and present explicit advice, whereas the practitioner’s orientation may involve respecting client autonomy. The practitioner must balance both positions to create appropriate boundaries that facilitate a productive alliance. This involves attention to the transference and countertransference related to culturally influenced power dynamics (Comas-Diaz & Jacobsen, 1991).

Pedersen (1991) argues that ‘empathic understanding’ is critical to build and maintain the relationship. Empathy is demonstrated through explicit understanding of the client’s experiences, expressing desire to learn more about the client’s culture, acknowledging any lack of knowledge of the client’s culture, clarifying vocabulary, and using modes of communication that enable the sending/receiving of messages accurately and sensitively (Alberta & Wood, 2009; Ridley, 1995; S. Sue, 1998; Sue, Arredondo, & McDavis, 1992; Sue & Sue, 1999).

4.3.3 Reaching a shared understanding.

When engaging minority groups it is important from the outset to attend to cultural variables whilst eliciting information, rather than wait for cultural issues to arise. Macdougall & Arthur (2001) suggest that unspoken cultural factors can hinder assessment and problem conceptualisation, and become a barrier to therapeutic alliance and change. The APA (2003) recommends gathering culturally and socio-politically relevant information about client history, such as: generational history; residency status (e.g., history of migration, asylum seeker); fluency in languages; extent of family/community support and resources; education, work history, and change in social status as a result of migration; and level of stress related to acculturation process. This will help the practitioner to differentiate between symptoms of intrapsychic stress and stress arising from social structure (Cross, 1995; Sue, Arredondo, & McDavis, 1992).

To reach shared understanding Sue (1998) endorses "scientific-mindedness". Scientific mindedness refers to the way inferences are *tested* rather than assumed on the basis of theory and/or knowledge relating to one cultural group. For example, when a client reports seeing spirits it could be interpreted as a psychotic episode, while the client understands the experience as a natural hallucination which carries meaning. Sue suggests that a practitioner with limited knowledge of the client's cultural group should test psychosis or natural hallucination hypotheses by investigating whether the experience is considered unusual in the cultural group (through exploration with the client, family or a knowledgeable individual), and whether other psychotic symptoms are manifested. By maintaining an open exchange and adopting this hypothesis testing method the practitioner can assess to what degree cultural factors are pertinent to the client and what responses are culturally influenced.

McCabe and Priebe (2004) suggest that consensual and shared explanatory models of illness between a client and practitioner may be associated with better therapeutic relationship and greater treatment satisfaction. Lopez (2006) expands the notion of shared understanding to the whole therapeutic encounter during which the practitioner must facilitate a co-constructed narrative which accommodates practitioner and client perspectives. This process demands that the practitioner balance legitimacy of the client's worldview with that of their own. Alberta & Wood (2009) cite the "diunital reasoning" of Myers (1988) as a skill that allows practitioners to accept and hold distinct concepts as valid and 'true'. Diunital reasoning enables the practitioner to accept and work with cultural understandings of problems, and what needs be done about them, rather than simply adopt understandings/solutions contained in Western models. Lopez (1997) emphasised the importance of being able to move between the two cultural perspectives of practitioner and client. The practitioner can access the client's cultural perspective and integrate/juxtapose it with their own as appropriate. The aim is to accommodate both client's and practitioner's

perspectives. The important thing is not the extent to which practitioner's or client's perspectives are adopted, but that the co-constructed narrative is amenable to both practitioner and client.

Tseng (2004) suggests that to flexibly integrate what the client brings explicitly and implicitly to therapy into a co-constructed narrative may require theoretical modification and philosophical reorientation on the part of the practitioner. Theoretical concepts to understand nature of mind, psychopathology and ways to seek solutions for psychological problems are embedded in clinical practice and may need to be modified to 'meet with' alternative understandings. Differences in worldview and existential position often demand philosophical reorientation on the part of the practitioner. To make sense of what the client brings the practitioner must discern whether there is 'functional equivalence' and/or 'conceptual equivalence' between their own philosophical and theoretical position and that of the client (Leong, 1997). Functional equivalence refers to whether psychological phenomena have similar function across cultures, e.g. a person moving out of the family home can hold different meanings to Eastern and Western cultures. Conceptual equivalence refers to whether two cultures have the same concept, or attach the same meaning to a concept. For example, the concept of 'mind' as a singular treatable feature of the person stems from a mind-body distinction that is commonly associated with Western perspectives. Western diagnosable disorders of the mind may therefore not have conceptual equivalence in other cultures.

The practitioner may need to align herself with a range of alternative theoretical positions and concepts relating to: self and personhood; interpersonal dependency and independence; psychosocial development; coping/defence mechanisms (Roland, 1988; Tseng, 2004). The practitioner should explore individual and group meanings associated with the client's comments, behaviours and emotional expression, in order to gain insight

into the individual's unique cultural outlook and adequately explain their experiences (Cross et al., 1989; Stuart, 2004).

Practitioners can, over time, accumulate a comprehensive knowledge of the cultural characteristics of communities they work amongst and this can inform hypothesis forming. However, Sue (1998) cautions against allowing stereotypes of cultural groups to permeate the practitioner's perceptions of, and attitude towards, a given cultural group. If this happens, the client's individual characteristics can be lost. On the other hand, to focus exclusively on the individual risks ignoring valuable information on cultural identity as shaped by links to cultural group(s). Sue proposed that the skill of "dynamic-sizing" is required by practitioners. Dynamic-sizing refers to the skills to know when to generalize and be inclusive and when to individualize and be exclusive. It allows one to avoid stereotypes of individuals while still acknowledging the importance of cultural group factors. The practitioner is able to place the client in context, according to whether they display characteristics typical of, or distinctive to, their cultural group.

4.3.4 Incorporating congruent strategies and goals.

There is a need to collaborate with the client to establish goals and tasks of therapy that are consistent with the salient dimensions of client culture (Sue & Sue, 1999). Cultural factors will influence how both practitioner and client understand human nature, problem development, and targets for change (APA, 2002; Pedersen, 2001). The practitioner brings expertise on the change process and the client brings expertise in their cultural context and the problem (Collins & Arthur, 2007).

Culture shapes the client's concept of nature and their attitude toward it. Nature may be regarded as something to be subservient to, rather than control (Sue & Sue, 1999). This is likely to influence a client's conceptualization of a problem (if it is perceived as 'natural') and what can or should be done about it. Western therapies can follow a cognitive, rational approach to understanding the nature and cause of problems, and how to

address them. A practitioner must evaluate whether a client views problems as something to overcome with personal strength and other resources, or whether their view is 'fatalistic' and accepting of limitations. The practitioner may need to reorient herself to accommodate an alternative philosophical position, and consider replacing strategies that imply 'overcoming' or 'solving' a problem with ones that incorporate 'acceptance' or 'coping' (Lo & Fung, 2003; Tseng, 2004).

Sue & Sue (1999) state that the practitioner should evaluate a client's and/or their family's culturally influenced orientation toward, and understandings and expectations of, psychotherapy. Client feedback during this process can draw attention to necessary 'technical adjustments' to the methods and practices of intervention (Tseng, 2004). To give an example, feedback may reveal a client's expectations of a therapeutic relationship that define the 'helper' as one who will 'administer' a treatment, or 'do something to/for the client; an expectation that may be associated with traditional help-seeking paradigm of another culture. Consequently Tseng (2004) suggests the practitioner may choose to be more directive in order to achieve the goals. In a practical sense, assessment feedback may suggest that client identity is strongly defined by the relations to family, community, or religious affiliation. This might lead the practitioner to consider actively involving family members in the intervention (Lo & Fung, 2003), or drawing on problem solving resources in the community (Nadirshaw, 2009).

The goal of therapy can be loosely categorised as reaching 'normality', however Offer & Sabshin (1974, as cited in Tseng, 2004) point out that normality can be represented by professional definition, by assessment of function or by definition according to sociocultural perspectives. Commonly held concepts of normality within a particular group vary according to culture, therefore goal-setting with a client may require a conciliation of understandings of normality for practitioner and client. A practitioner must also consider whether the client's normality and associated goals are consistent with the normality of

their primary group (Lo & Fung, 2003). For example, a South Asian person's desire to be autonomous may conflict with the values of their family. In setting appropriate goals, the practitioner would have to consider the continuous well-being of the client in their environmental context.

5. Discussion

The reviewed literature suggests that at the individual level there are a constellation of characteristics that define the 'culturally competent practitioner'. These involve a clinician who:

- is aware of their own personal and professional values and biases, and how these may influence their perceptions of an 'other', their problem, and the therapeutic relationship.
- has acquired, or knows how to acquire, cultural knowledge relevant to the client.
- has the skill to intervene to alleviate distress of the client in a culturally responsive way.

Awareness was reflected in the three key themes of: awareness of 'self', of 'other', and of the 'social and political context'. Self awareness related to the practitioner's self-scrutinising position toward their own worldview, values, assumptions, beliefs and behaviours. Awareness of other involved sensitivity to the multiple dimensions of identity that a person will hold and which may be salient to the therapeutic context. Awareness of the social and political context involves attention to the external forces that can impact on a client and the internalised messages a client may hold as a result of those forces. Knowledge referred to practitioner understanding of theory and practice relevant to all cross-cultural encounters, as well as to knowledge of the characteristics of specific cultural groups. Both are considered necessary for culturally competent practice.

Skills could be organised under the themes of ‘communication and language’, ‘building the therapeutic relationship’, ‘reaching a shared understanding’ and ‘incorporating congruent strategies and goals’. Communication skills related to use of interpreters, the ability work with varied verbal and non-verbal communication styles, and the ability to accommodate linguistic and conceptual difference across cultures. Skills in building the therapeutic relationship involved technical adjustments to intervention style, establishing therapist credibility, attention to boundaries, and the demonstration of willingness to learn about cultural background. Reaching a shared understanding referred to exploration of cultural issues, open hypothesising, integrating therapist-client perspectives, modifying one’s own theoretical perspectives, and contextualising group knowledge. Finally, incorporating congruent strategies and goals referred to practitioner attention to how a client’s philosophical orientation can influence problem conceptualisation, normality, solutions, and expectations of therapy.

There is overlap between the key facets of cultural competence. For example, awareness of the ways culture is relevant to a client demands generic and group-specific knowledge, and skills stem from awareness and knowledge. Writers place emphasis on different facets and describe the features and processes relevant to those facets but, in general, literature that prescribes cultural competency fits within this framework.

5.1 Criticisms of cultural competency

Whilst the current review delineates cultural competency in a therapy context, the cultural competency approach as means to ‘work with difference’ is not endorsed by all theorists. Some have challenged the promotion of cultural competency. Below are some of the challenges:

Satel and Forster (1999) and Satel (2000) argue that *cultural competency is motivated by ‘political correctness’ and is unsupported by an evidence base*. Furthermore,

others such as Worthington and Dillon (2010) suggest that evidence to support practitioner cultural competence as a valid construct that warrants a distinction from general practitioner competence is mixed. To define and research cultural competency has proved difficult because it is a way of construing therapeutic encounter and involves more that just technique (S. Sue, 1998); it also involves the practitioner, the client and the context. These key elements are distal to therapeutic outcome (Sue & Zane, 1987). For example, cultural knowledge must be transformed into therapeutic strategies, as relevant to a specific client. What a practitioner *does* on the basis of knowledge is therefore of greater significance to outcome. To conduct process and outcome studies to evaluate practitioner cultural competence is therefore methodologically challenging. Unsurprisingly, evidence that practitioner competence improves equity of service across cultural groups is weak (Beach et al., 2005).

A further criticism of the concept is articulated by Weinrach and Thomas (2002) who argue that *to position cultural competence as a requisite for work with certain groups on the basis of ethnicity discriminates against groups defined by other diversity characteristics such as gender, [dis]ability, social class or sexual orientation.* Although writers have emphasised different facets of cultural competence, the current article reiterates that cultural competence involves an awareness of, and ability to work with, the multi-dimensional nature of cultural identity. The practitioner must be sensitive to all elements of client identity, and not inadvertently elevate the significance of ethnicity at the expense of other aspects of identity such as gender, [dis]ability etc. However, Bernal & Scharron-Del-Rio (2001) argue that an emphasis on the ethnocultural dimension of cultural competence is warranted because psychotherapy is a cultural phenomenon with implicit and explicit Eurocentric bias. Psychological approaches contain values and concepts that can conflict with those of many minority ethnic groups.

Another criticism is that *to ascribe typical characteristics and behaviours to members of cultural groups is inadvertently prejudicial, stereotypic, and fails to attend to the client's individuality* (Hwang, 2006; Weinrach & Thomas, 2002; 2004). Cultural competence has been shown to involve: practitioner awareness of their own, and society's, tendency to stereotype (APA, 2003; Collins & Arthur, 2007; Daniels et al., 2004); and the skills to draw on cultural group knowledge to arrive at a shared and idiosyncratic account.

Patterson (2004) also argues that t*o adopt a position that imparts greater relevance to client differences than to similarities ignores the universal applicability of client-centred therapies. And, to assume that having cultural knowledge about clients will lead to more effective therapy reduces psychological intervention to simply a matter of information, methods, skills or techniques. The positive impact of what is common to all encounters, the therapeutic relationship, is undervalued in its universal capacity to help 'any' person.* Patterson's comments draw attention to a tension between what are referred to as *etic* and *emic* positions (Berry, 1980). The etic position makes assumptions about the universal relevance of phenomena. A phenomenon can be 'discovered' in one society and deemed a 'reality' for all societies. Aspects of clinical practice are therefore applied to all cultural groups with some adaptation of an application for a given cultural group. Cultural competence therefore means to modify 'universal' psychological applications on the basis of acquired knowledge about cultural groups. This etic approach is implicit in Western psychology theory and practice. Patterson's point that cultural competency reduces psychological intervention to a matter of information, method, skills and techniques may carry some weight. Cultural competence is to some degree a matter of modifying Western practice through the aptitudes of the practitioner. However, to avoid this through adherence to 'evidence-based' universals of the psychotherapy paradigm (as Patterson argues), such as those related to therapeutic alliance, is still an etic approach that may extend concepts and meaning systems to populations in which they have no foundation.

The emic position frames all psychological processes as culturally constituted meaning systems. People's experiences are made sense of from within a cultural system rather that by the application of accepted psychological universals. An individual's experiences are therefore evaluated relatively to the internal characteristics of a culture. The emic perspective also has its limitations, one being that it downplays the existence of universal human qualities and experiences (e.g. Krause, 1989).

Cultual competency in therapy as described in the current article does not fall neatly into either the etic or emic categories. There are aspects of the approach that apply human psychological universals and make modifications on the basis of culture. However, also evident is the attempt to understand client experience in the context of their cultural group(s). Difficulty in meeting clients' needs might be associated with practice that fall exclusively into the one category.

5.2 The case for a paradigm shift

Construal of cultural competency as a means to manage cultural issues in therapy through modification of Western psychology practice, has led some writers to argue for a paradigm shift that reframes psychological theory and practice to render it more compatible with the needs of diverse populations (e.g. Comas-Diaz, 1992; Pedersen, 2001). As a means to understand the role of cultural issues in the mental well-being of diverse populations, cultural competency is seen as a necessary stage in the evolution of psychotherapeutic practice. However a more pluralistic approach is ultimately required. Many of the universal psychotherapeutic constructs that define normality, health and relationships, and that have permeated mainstream psychology will be perceived as culture-bound interpretations (Comas-Diaz, 1992). A repertoire of alternative psychological values and concepts will be available to the practitioner and they will endeavour to understand all human behaviour and

experience in its cultural context, thereby meeting the needs of each unique client. In the meantime, cultural competency can be a valuable, albeit interim, approach.

5.3 Implications of cultural competency

Despite the limitations of research to 'test' cultural competence there is an expanding body of *theoretical* literature that highlights the importance of cultural competency in producing better outcomes (see Sue, Zane et al., 2009). Sue (2003) argues that theory-driven research should continue as a valid strand that informs cultural competency practice and policy guidelines whilst the evidence accumulates. Also, the 'American Psychological Association Presidential Task Force on Evidence-Based Practice in Psychology' (2006) agreed to define evidence-based practice as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (p. 271), thus acknowledging the value of subjective clinical judgment as a necessary accompaniment to the empirical approach.

Research findings are seldom 'conclusive' and policy and practice is also driven by clinical expertise, ethical and moral perspectives, public opinion, and social and political considerations. In the UK, established governement policy aims to bridge the gap in equitable mental health service provision for minority groups by developing culturally competent practice at every level (DoH, 2005; 2006; 2009), yet the strategy is arguably more value-based than it is evidence-based. In order to act in accordance with governement policy, institutions that regulate and train professionals who deliver the range of therapeutic modalities available in the UK need to ensure that curriculums, training programmes, Best Practice guidelines, National Occupational Standards, and Knowledge and Skills Frameworks endorse and include practitioner cultural competency as dictated by the state-of-play of contemporary research. Cultural competency in the context of therapeutic

intervention involves developing a workforce that is culturally competent, i.e. competent to work with cultural processes as outlined in the current article.

Work by proponents of specific therapeutic modalities to introduce cultural competency to the corresponding theoretical frameworks is under way. For example, Hays (2010) discusses the challenges of incorporating the approach in Cognitive-Behavioural Therapy (CBT), and demonstrates ways of applying its principles to CBT practice. In this modality and in others, however, more research is required, including that which can investigate the impact of practitioner competence (Sue, Zane et al., 2009).

The current article has aimed to delineate cultural competence as it applies to all psychological interventions. It has drawn upon a range of clinical expertise and opinion that converges into a well-established framework encompassing the need for practitioners' cultural awareness, knowledge and skills. Cultural competence is an ongoing process that demands the active engagement of practitioners, supported by competent policies and institutions. It is a formidable, self-scrutinizing task that develops practitioners so that they can integrate and work with alternative cultural and psychological understandings to the ones they hold. The culturally competent practitioner is not one who simply acquires knowledge, but rather sustains a curious and open position that makes meaning of the dynamic construct that is culture.

6. References

*Alberta, A., & Wood, A. (2009). A practical skills model for effectively engaging clients in multicultural settings. *The Counseling Psychologist, 37* (4), 564-579.

American Psychological Association. (1993). *Guidelines for providers of services to ethnic, linguistic and culturally diverse populations.* Washington DC: Author.

*American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58* (5), 377-402.

Balcazar, F., Suarez-Balcazar, Y., Taylor-Ritzler, T., & Keys, C. (2010). *Race, culture and disability: Rehabilitation science and practice.* Masschusetts: Jones & Bartlett Publishers.

Beach, M., Price, E., Gary, T., Robinson, K., Gozu, A., Palacio A., . . . Cooper, L. (2005). Cultural competence: a systematic review of health care provider educational interventions. *Medical Care, 43* (4), 356-373.

Bennett, J., Kalathil, J., & Keating, F. (2007). *Race equality training in mental health services in England. does one size fit all?* London: Sainsbury Centre for Mental Health.

Bernal, G., & Scharron-Del-Rio, M. (2001). Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. *Cultural Diversity and Ethnic Minority Psychology, 7* (4), 328-342.

Berry, J. (1980). Introduction to methodology. In H. Triandis, & J. Berry (Eds.), *Handbook of cross-cultural psychology: Vol. 2. Methodology* (pp. 1-28). Boston: Allyn & Bacon.

Berry, J., & Kim, U. (1988). Acculturation and mental health. In P. Dasen, J. Berry, & N. Sartorius (Eds.), *Cross-cultural research and methodology series Vol. 10. Health*

and cross-cultural psychology: Towards applications (pp. 207-236). Thousand Oaks, CA: Sage.

Berry, J., & Sam, D. (1996). Acculturation and adaptation. In J. Berry, & M. Segall (Eds.), *Handbook of cross-cultural psychology. Volume 3. Social behavior and applications* (pp. 291-325). Boston: Allyn & Bacon.

Betancourt, J., & Green, A. (2010, April). Linking cultural competence training to improved health outcomes: perspectives from the field. *Academic Medicine*, pp. 583-585.

Bhui, K. (2002). The future of mental health care: essential elements. In K. Bhui (Ed.), *Racism & mental health: prejudice and suffering* (pp. 217-227). London: Jessica Kingsley Publishers.

Bhui, K., & Bhugra, D. (2004). Communication with patients from other cultures: the place of explanatory models. *Advances in Psychiatric Treatment, 10*, 474-478.

Bhui, K., & Bhugra, D. (2007). Ethnic inequalities and cultural capability framework in mental healthcare. In K. Bhui, & D. Bhugra (Eds.), *Textbook of cultural psychiatry* (pp. 81-92). Cambridge: Cambridge University Press.

Blackwell, D. (2005). *Counselling and psychotherapy with refugees.* London: Jessica Kingsley Publishers.

Bozarth, J. (1998). *Person-centred therapy: A revolutionary paradigm.* Ross-on-Wye: PCCS Books.

*Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: A model of care. *Journal of Transcultural Nursing, 13*, 181-184.

*Collins, S., & Arthur, N. (2007). A framework for enhancing multicultural counselling competence. *Canadian Journal of Counselling, 41* (1), 31-49.

Comas-Diaz, L. (1992, Spring). The future of psychotherapy with ethnic minorities. *Psychotherapy, 29* (1), pp. 88-94.

Comas-Diaz, L., & Jacobsen, F. (1991). Ethnocultural transference and countertransference in the therapuetic dyad. *American Journal of Orthopsychiatry, 61*, 392-402.

*Cross, T., Brazen, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care.* Washington DC: Georgetown University Child Development Center.

Cross, W. (1995). The psychology of nigrescence: revising the Cross model. In J. Pontoretto, J. Casas, L. Suzuki, & C. Alexander (Eds.), *Handbook of multicultural counseling.* Thousand Oaks, CA: Sage.

*Daniels, J., Roysircar, G., Abeles, N., & Boyd, C. (2004). Individual and cultural-diversity competency: focus on the therapist. *Journal of Clinical Psychology, 60* (7), 755-770.

Department of Health. (2003). *Inside/Outside.* London: Department of Health.

Department of Health. (2005). *Delivering race equality in mental health care: An action plan for reform inside and outside services.* London: Department of Health.

Department of Health. (2009). *Delivering race equality in mental health care: A review.* London: Department of Health.

Department of Health. (2009). *Department of health single equality scheme.* London: Author.

Eleftheriadou, Z. (2002). Transcultural counselling and psychotherapy: A philosophical framework. In S. Palmer (Ed.), *Multicultural counselling: A reader.* (pp. 31-39). London: Sage.

Fernando, S. (1991). *Mental health, race and culture.* London: Macmillan MIND.

Fuertes, J., Stracuzzi, T., Bennett, J., Scheinholtz, J**.,** Mislowack**,** A., Hersh, M., & Cheng, D. (2006). Therapist multicultural competency: a study of therapy dyads. *Psychotherapy: Theory, Research, Practice, Training, 43* (4), 480-490.

Griner, D., & Smith, T. (2006). Culturally adapted mental health intervention: a meta-analytic review. *Psychotherapy: Theory, Research, Practice, Training, 43* (4), 531-548.

Gumperz, J., Jupp, T., & Roberts, C. (1981). *'Cross-talk' - The wider perspective.* Middlesex: Industrial Language Training Laboratory.

Hall, E. (1976). *Beyond Culture.* New York: Anchor Press/Doubleday.

Hall, G., Iwamasa, G., & Smith, J. (2003). Ethical principles of the psychology profession and ethnic minority issues. In W. O'Donohue, & K. Ferguson (Eds.), *Handbook of Professional Ethics for Psychologists: Issues, Questions, and Controversies* (pp. 301-318). Thousand Oaks, CA: Sage.

Halsey, R., & Patel, M. (2003). Perils of race and culture for clinical psychology trainees. The missionary position in the 21st century. *Clinical Psychology Forum, 28*, 29-32.

Hays, P. (2001). *Addressing cultural complexities in practice: A framework for clinicians and counselors.* Washington DC: American Psychological Association.

Helms, J. (1990). *Black and White racial identity: Theory, research and practice.* Conneticut: Greenwood Press.

Helms, J. (1995). An update of Helms' White and People of Color racial identity models. In J. Ponterotto, J. Casas, L. Suzuki, & C. Alexander (Eds.), *Handbook of multicultural counselling.* (pp. 181-198). Thousand Oaks, CA: Sage.

Horrell, S. (2008). Effectiveness of cognitive behaviour therapy with adult ethnic minority clients. A review. *Professional Psychology: Research and Practice, 39* (2), 160-168.

Hwang, W. (2006). The psychotherapy adaptation and modification framework: application to Asian Americans. *American Psychologist, 61* (7), 702-715.

Krause, I. (1989). Sinking heart: A Punjabi communication of distress. *Social Science and Medicine, 29* (4), 563-575.

Lago, C. (2006). *Race, culture and counselling: The ongoing challenge.* (2nd ed.). Maidenhead: Open University Press.

Laungani, P. (1997). Replacing client-centred counselling with culture-centred counselling. *Counselling Psychology Quarterly, 10* (4), 343-351.

Lee, C. (2006). Updating the models of identity development. In C. Lago (Ed.), *Race, culture and counselling: The ongoing challenge* (pp. 179-186). Maidenhead: Open University Press.

*Leong, F. (1997). Cross-cultural career psychology: Comment on Fouad, Harmon, and Borgen (1997) and Tracey, Watanabe, and Schneider (1997). *Journal of Counselling Psychology, 44*, 355-359.

*Lo, H., & Fung, K. (2003). Culturally competent psychotherapy. *Canadian Journal of Psychiatry, 48* (3), 161-170.

*Lopez, S. (1997). Cultural competence in psychotherapy: A guide for clinicians and their supervisors. In C. Watkins (Ed.), *Handbook of psychotherapy supervision* (pp. 570-588). New York: Wiley.

Lopez, S. (2006). Cultural competence and psychotherapy: Applying anthropologically informed conceptions of culture. *Psychotherapy: Theory, Research, Practice, Training, 43* (4), 380-396.

*Macdougall, C., & Arthur, N. (2001). Applying racial identity models in multicultural counselling. *Canadian Journal of Counselling, 35* (2), 122-136.

Mollen, D., Ridley, C., & Hill, C. (2003). Models of multicultural counselling competence: A crticial evaluation. In D. Pope-Davis (Ed.), *Handbook of multicultural competencies in counselling and psychology* (pp. 21-37). California: Sage.

*Nadirshaw, Z. (2009). Race, culture and ethnicity in mental health care. In R. Newall, & K. Gournay (Eds.), *Mental health nursing: An evidence based approach.* (2nd ed., pp. 39-55). London: Churchill Livingstone.

National Institute for Health and Clinical Excellence. [NICE]. (2009). The NICE guideline on the treatment and management of depression in adults. Retrieved July 17, 2011, from NICE Guidance Web site: http://guidance.nice.org.uk/nicemedia/live/12329/45896/45896.pdf

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Mahtani, A., Miller, A., & Nadirshaw, Z. (2000). *Clinical psychology. Race and culture: a training manual.* Leicester: British Psychological Society.

Patterson, C. (2004). Do we need multicultural counseling competencies? *Journal of Mental Healh Counseling, 26* (1), 67-73.

*Pedersen, P. (1995). The culture-bound counsellor as an unintentional racist. *Canadian Journal of Counselling, 29,* 197-205.

Pedersen, P. (2001). Multiculturalism and the paradigm shift in counselling. Controversies and alternative futures. *Canadian Journal of Counselling, 35* (1), 15-25.

Ponterotto, J., & Pedersen, P. (1993). *Preventing Prejudice.* Newbury Park, CA.: Sage.

Rathod, S., Kingdon, D., Phiri, P., & Gobbi, M. (2010, July 15). Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions. *Behavioural and Cognitive Psychotherapy*, pp. 1-23.

*Ridley, C. (1995). *Overcoming unintentional racism in counseling and therapy: A practitioner's guide to intentional intervention.* Thousand Oaks, CA: Sage.

Roland, A. (1988). *In search of the self in India and Japan: Toward a cross-cultural psychology.* Guildford: Princeton University Press.

Satel, S. (2000). *How political correctness is corrupting medicine.* New York: Basic Books.

Satel, S., & Forster, G. (1999). *Multicultural mental health: Does your skin color matter more than your mind?* Washington, DC: Center for Equal Opportunity.

Schilling, B., & Brannon, E. (1986). In E. Randall-David (Ed.), *Strategies for workng with culturally diverse communities and clients.* Washington DC: Association for the Care of Children's Health.

St. Clair, A., & McKenry, L. (1999). Preparing culturally competent practitioners. *Journal of Nursing Education, 38* (5), 228-234.

*Stuart, R. (2004). Twelve practical suggestions for achieving multicultural competence. *Professional Psychology: Research and Practice, 35* (1), 3-9.

Sue, D. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist, 29* (6), 790-821.

*Sue, D., Arredondo, P., & McDavis, R. (1992, March/April). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling and Development*, pp. 477-486.

Sue, D., & Sue, D. (1990). *Counselling the culturally different. Theory and practice.* (2nd ed.). New York: Wiley.

*Sue, D., & Sue, D. (1999). *Counselling the culturally different. Theory and practice.* (3rd ed.). New York: Wiley.

Sue, D., & Torino, G. (2005). Racial-cultural competence: Awareness, knowledge, and skills. In R. Carter (Ed.), *Handbook of racial-cultural psychology and couseling: Vol. 2. Training and Practice.* (pp. 3-18). Hoboken, NJ: Wiley.

*Sue, S. (1998). In search of cultural competence in psychotherapy and counselling. *American Psychologist, 53* (4), 440-448.

Sue, S. (2003). In defense of cultural competency in psychotherapy and treatment. *American Psychologist, 58* (11), 964-970.

*Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42* (1), 37-45.

Sue, S., & Zane, N. (2009). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *Asian American Journal of Psychology*, (S1), 3-14.

Sue, S., Zane, N., Hall, G., & Berger, L. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525-548.

*Toporek, R., & Reza, J. (2001). Context as a critical dimension of multicultural counseling: Articulating personal. professional, and institutional competence. *Journal of Multicultural Counseling and Development, 49*, 13-31.

Tribe, R., & Raval, H. (2003). *Workng with interpreters in mental health.* London.: Brunner-Routledge.

*Tseng, W. (2004). Culture and psychotherapy: Asian perspectives. *Journal of Mental Health, 13* (2), 151-161.

Vontress, C., & Jackson, M. (2004). Reactions to the multicultural counseling competencies debate. *Journal of Mental Health Counseling, 26*, 74-80.

Webb Johnson, A. (1993, March 9). Cultural Divide. *Counselling News*, pp. 26-27.

Weinrach, S., & Thomas, K. (2002). A critical analysis of the multicultural counseling competencies: implications for the practice of mental health counseling. *Journal of Mental Health Counseling, 24* (1), 20-35.

Weinrach, S., & Thomas, K. (2004). The AMCD multicultural counseling competencies: a critically flawed initiative. *Journal of Mental Health Counseling, 26*, 81-93.

Worthington, R., & Dillon, F. (2010, December 20). Deconstructing multicultural counseling competencies research. *Journal of Counseling Psychology*. Advance online publication. doi: 10.1037/a0022177.

Appendix

Table 2: Details of core articles and chapters from the review.

	Title	Author	Year	Country of origin	Type of information. i.e. guidance / empirical study / review
1.	A practical skills model for effectively engaging clients in multicultural settings.	Alberta, A., & Wood, A.	2009	US	Guidance
2.	Guidelines on multicultural education, training, research, practice, and organizational change for psychologists.	American Psychological Association.	2003	US	Guidance
3.	The process of cultural competence in the delivery of healthcare services: A model of care.	Campinha-Bacote, J.	2002	US	Guidance
4.	A framework for enhancing multicultural counselling competence.	Collins, S., & Arthur, N.	2007	Canada	Guidance
5.	Towards a culturally competent system of care.	Cross, T., Brazen, B., Dennis, K., & Isaacs, M.	1989	US	Guidance
6.	Individual and cultural-diversity competency: focus on the therapist.	Daniels, J., Roysircar, G., Abeles, N., & Boyd, C.	2004	US	Guidance
7.	Cross-cultural career psychology: Comment on Fouad, Harmon, and Borgen (1997) and Tracey, Watanabe, and Schneider (1997).	Leong, F.	1997	US	Guidance
8.	Culturally competent psychotherapy.	Lo, H., & Fung, K.	2003	Canada	Guidance and single case study examining influences of culture on presentation, formulation, and treatment of a Chinese Canadian male.
9.	Cultural competence in psychotherapy: A guide for clinicians and their supervisors.	Lopez, S.	1997	US	Guidance
10.	Applying racial identity models in	Macdougall, C., &	2001	Canada	Guidance

	multicultural counselling.	Arthur, N.			
11.	Race, culture and ethnicity in mental health care.	Nadirshaw, Z.	2009	UK	Guidance
12.	The culture-bound counsellor as an unintentional racist.	Pedersen, P.	1995	Canada	Guidance
13.	Overcoming unintentional racism in counseling and therapy: A practitioner's guide to intentional intervention.	Ridley, C.	1995	US	Guidance
14.	Twelve practical suggestions for achieving multicultural competence.	Stuart, R.	2004	US	Guidance
15.	Counselling the culturally different. Theory and practice.	Sue, D., & Sue, D.	1999	US	Guidance
16.	Multicultural counseling competencies and standards: A call to the profession.	Sue, D., Arredondo, P., & McDavis, R.	1992	US	Guidance
17.	In search of cultural competence in psychotherapy and counselling.	Sue, S.	1998	US	Guidance
18.	The role of culture and cultural techniques in psychotherapy: A critique and reformulation.	Sue, S., & Zane, N.	1987	US	Guidance
19.	Context as a critical dimension of multicultural counseling: Articulating personal. professional, and institutional competence.	Toporek, R., & Reza, J.	2001	US	Guidance
20..	Culture and psychotherapy: Asian perspectives.	Tseng, W.	2004	US	A review of literature on Asian (American) perspectives on psychotherapy and clinical experiences of Asian clinicians, to identify cultural considerations relevant to psychotherapeutic practice.

An Investigation of Cultural Competency in the Experiences of Therapists Newly Trained to Deliver Cognitive-Behavioural Therapy

1. Abstract

Background: Policies and guidance on the provision of mental health services to the diverse UK population acknowledge the need for therapists to be able to deliver psychological interventions in a culturally sensitive way to meet the needs of Black and Minority Ethnic groups. Research contains comprehensive guidance on what culturally competent practice involves, however, training does not comprehensively incorporate the guidance. It is unclear whether Cognitive-Behavioural Therapists' practice is consistent with the guidance, or whether the training they receive engenders cultural competency.

Aims: The current study aimed to explore the experiences and views of therapists emerging from the Improving Access to Psychological Therapies training programme in order to gain preliminary insight into whether their practice is culturally sensitive and consistent with cultural competency guidance. Another aim was to investigate how the training approach contributes to therapists' capacity to work in a culturally sensitive way.

Method: Focus groups were conducted with participants from three services providing CBT interventions. Semi-structured interviews were used to facilitate discussion on the influences of culture in therapy, the way participants respond to those influences, and from where they consider their abilities to have originated. The interviews were recorded and transcribed, and the data analysed using Template Analysis.

Results: Participants' feedback demonstrated a range of perspectives and practices that were consistent with cultural competency guidance in the literature. Abilities were attributed to personal and professional experience, and to personal motivation to develop the capacity to work sensitively. Training was not considered to have significantly contributed to cultural competency and suggestions for how it may be improved were presented.

Conclusions: It appears possible for therapists to work in a culturally sensitive way without a comprehensive training based on cultural competency guidance. Learning from personal and professional life experience might be primary contributors to cultural competency rather than training. Training might however be improved by responding to therapists' feedback.

2. Introduction

Department of Health (DoH) papers such as *Inside/Outside* (2003), *Delivering Race Equality* [DRE]*: A Framework for Action* (2003) and *The Single Equality Scheme* (2009) all outlined initiatives to meet the health care needs of a population diverse in gender, race, ethnicity, sexual orientation, age, religion, [dis]ability, language, national origin, immigration status and socioeconomic status. Specifically in relation to mental health care, the *Delivering Race Equality in Mental Health Care* action plan (DRE; DoH, 2005) sought to ensure that a person's access to mental health intervention was not hindered on the basis of their cultural background, ethnicity or faith.

The UK mental health sector acknowledges that equitable service provision for a diverse population requires competence at policy-making, organisational and individual levels (Bennett, Kalathil, & Keating, 2007; Bhui & Bhugra, 2007; DoH, 2003; Hall, Iwamasa, & Smith, 2003). The term 'cultural competency' has been adopted to label this requirement. Cross, Brazen, Dennis, and Isaacs (1989) defined cultural competence as:

> "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations. The word "culture" is used because it implies the integrated pattern of human behaviour that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively." (1989, p. 13)

One key area of cultural competency research and development has been at the individual level, i.e. the competence required of mental health professionals to work in a culturally sensitive way in their clinical practice. Sue, Arredondo, and McDavis (1992) argued that although culture can be broadly defined to include age, class, religion, race,

ethnicity, sexual orientation etc., to limit all cultural competency approaches to such a broad application can serve to neglect the needs of specific cultural groups. Therefore a cultural competency focus on racial and ethnic factors has been given specific research attention.

2.1 Culturally competent practitioners

There is wealth of literature on what cultural competency means at the level of individual clinical practice. Some work has focused on specific disciplines, e.g. Nursing, Counselling, Social Work (see for reviews Balcazar, Suarez-Balcazar, Taylor-Ritzler, & Keys, 2010; Mollen, Ridley, & Hill, 2003). The application of cultural competence to psychotherapeutic interventions has arguably warranted a more complex approach. Bernal and Scharron-Del-Rio, (2001) highlight that psychotherapy is itself a cultural phenomenon that plays a key role in treatment process. Western psychological approaches contain theoretical positions and philosophical orientations that are shaped by the culture in which they evolved. A practitioner delivering psychological interventions must continuously reflect on the validity and application of inherent theories and philosophies for each client that they engage (Tseng, 2003).

Different psychotherapy schools have begun to consider how cultural competency fits with their theoretical frameworks, however much research has focused on intervention technique (Sue, Zane, Hall, & Berger, 2009). Lago (2006) and Webb Johnson (1993) have suggested that therapeutic modality is not as significant as practitioner characteristics and aptitude. The idea is not objectionable when one considers the evidence that factors relating to the client (commitment, motivation etc.) and the quality of the therapeutic relationship are the most critical elements to outcome (see Bozarth, 1998). Furthermore, Fuertes et al. (2006) found that practitioners rated highly by ethnic minority clients on therapeutic alliance and empathy were also rated higher in cultural competency.

Perspectives on practitioner cultural competence have emerged from various schools, especially counselling/counselling psychology, most noticeably since the work of Cross et al. (1989) which proposed a framework for a culturally competent system of care, and Sue, Arredondo, & McDavis (1992) which presented a comprehensive competency framework for counsellors. In response to such contributions the American Psychological Association (APA) produced specific guidance to meet diverse needs (2002; 1993). The broad literature on practitioner cultural competency takes into account the practitioner, the client and the context (S. Sue, 1998). Cultural competence literature converges into the three key areas of *awareness, knowledge* and *skills* (D. Sue, 2001) that enable the practitioner to work with a culturally diverse population. Warren (2000) describes cultural competence as "the process whereby persons develop levels of cultural awareness and then knowledgeably, skilfully, and actively use these levels in a variety of areas." (p. 135).

The literature suggests that a practitoner must have an awareness that differences in communication, worldview, relations and definitions of health, can impact on therapeutic encounter and outcome (e.g. Cross et al., 1989; Sue, Arredondo, & McDavis, 1992). To be able to work with such diffences one must develop an awareness of how cultural background shapes one's own perspective, and how it can shape the perspective of a potential client. Cultural awareness is linked to knowledge. Researchers suggest that a practitioner must acquire knowledge of theory and practice relevant to cross-cultural therapeutic encounters, as well as knowledge of the characteristics of specific cultural groups with which they might work (e.g. Campinha-Bacote, 2002; Lo & Fung, 2003). Finally, the literature highlights that a practitioner must acquire the skills to utilise awareness and knowledge in therapeutic practice, and make culture-centred adjustments (e.g. APA, 2003; Sue, Arredondo, & McDavis, 1992). Such skills apply to communication and language, building a therapeutic alliance, reaching a therapist-client shared understanding, and adopting appropriate intervention strategies and goals (see Bassey,

2011). The development of cultural competence is considered by many writers to be a lifelong process during which the individual continually grows in awareness, knowledge and skills (Eleftheriadou, 2002; Lopez, 1997; Pedersen, 2001; Sue, Arredondo, & McDavis, 1992).

2.2 Cultural competency and Cognitive-Behavioural Therapy

Cognitive-Behavioural Therapy (CBT) can be viewed as an umbrella term for a range of psychological techniques that share a theoretical basis in a behaviouristic learning theory and cognitive psychology. Essentially it is a psychotherapeutic approach that aims to address dysfunctional emotions, cognitions and behaviours through a goal-oriented, systematic procedure. The objective is typically to identify and monitor thoughts, assumptions, beliefs and behaviours that are related to negative emotions, and to target those which are dysfunctional, inaccurate or unhelpful. The aim is to replace them with those which are more realistic and useful, thus alleviating symptoms and facilitating lasting change.

Cultural competency research in CBT has taken a different direction to the one described above which focuses on the aptitudes required of a therapist to work in a culturally sensitive way with diverse individuals. Instead, research into how cultural factors influence the practice of CBT has taken what can be called a 'categorical' approach. This involves researching what modifications may be required to a CBT intervention for a particular group category. Much of this research has been conducted in the US with minority ethnic groups (see Horrell, 2008; Griner & Smith, 2006), however UK researchers have adopted a similar approach and begun to develop CBT protocols for UK Black and Minority Ethnic (BME) groups (Rathod, Kingdon, Phiri, & Gobbi, 2010).

The categorical approach is arguably more suited to some research methods, such as controlled trials, used to build evidence of treatment efficacy (Hays, 2010; S. Sue, 2003)

and this may explain the bias toward categorisation. However several writers have criticised categorical approaches because of their capacity to stereotype and assign sets of beliefs, values and/or behaviours to cultural groups, and thereby neglect individual differences (e.g. Hwang, 2006; Weinrach & Thomas, 2002; 2004). Some researchers have begun to consider how a more culturally responsive CBT can be developed through integration of the principles of cultural competence with CBT theory and practice (e.g. Hays, 2010). The aim is to develop CBT practitioners who are able to accomodate cultural factors when working with any client as opposed to adopting a protocol designed for a specific group with which a client may be associated.

2.3 Cultural competency and Improving Access to Psychological Therapies

Improving Access to Psychological Therapies (IAPT) is a UK national programme, launched by the DoH in May 2007. Its focus is to deliver psychological therapy for adults with common mental health problems, predominantly targeting depression and anxiety disorders. CBT is the most commonly applied mode of treatment under IAPT. It is deemed to have the most substantial evidence base supporting its effectiveness in the treatment of depression and anxiety, and is also recommended by the National Institute for Health and Clinical Excellence [NICE] for post-traumatic stress disorder, obsessive-compulsive disorder and body dysmorphic disorder (NICE, 2005a; 2005b; 2009; 2011).

The IAPT training programme attempts to hone all therapists' competencies to facilitate the delivery of specialist therapy to persons of diverse cultural backgrounds. The competencies for therapists who may be delivering CBT for anxiety and/or depressive disorders, have been devised by Roth and Pilling (2007). In the CBT competencies document, 'cultural competence' is highlighted as an important factor that can affect the effectiveness of an intervention. Rather than being expressed as a competency or metacompetency relating to effective delivery of CBT, it was considered a 'generic

therapeutic competency' that is embedded in other frameworks such as the Ten Essential Shared Capabilities (Hope, 2004), and National Occupational Standards. It is thus viewed as fundamental to CBT competencies, but not adopted as an explicit CBT competency. This was consistent with the method utilised to identify CBT competencies by Roth and Pilling which involved including only those which had supporting evidence linking them to positive outcome. Literature that proposes cultural competency guidance or frameworks for therapists is largely theory-driven, and not clearly linked to better outcomes (Beach et al., 2005). A strong body of theoretical literature does, however, highlight the importance of cultural competency in producing better outcomes (see Sue, Zane, Hall, & Berger, 2009). Also, writers have articulated the reasons why theory-driven research should continue as a valid strand that informs cultural competency practice and policy whilst the evidence accumulates (S. Sue, 2003).

In the national curriculum for training of CBT therapists for IAPT (DoH, 2008), which is based on the aforementioned competencies, cultural competence is not mentioned specifically but the learning outcomes for all modules include the "ability to adapt CBT sensitively, and to ensure equitable access for people from diverse cultures and with different values." (DoH, 2008, p.10). Cultural competency is therefore recognised as an essential element of therapist competency, however a prescriptive approach towards what constitutes a 'culturally competent' CBT therapist is not adopted. Institutions that are commissioned to train persons to deliver CBT in IAPT services are directed to engender cultural competency, but can exercise some discretion in relation to how this is achieved.

2.4 Implications of cultural competency guidance to UK practice

Cultural competency literature is comprehensive. It describes the awareness, knowledge and skills said to be required of all professionals delivering psychological interventions to a diverse population. IAPT is a means to meet the psychological needs of

the UK population including BME groups. It aims to address common mental health problems on a scale never seen before in the UK In this endeavour it has invested a great deal in the capacity of CBT, and the therapists delivering it, to alleviate problems.

The IAPT programme recognises the need to develop the cultural competency of its workforce by drawing on the literature to inform practice (DoH, 2008). However, guidance contained within the cultural competency literature has not been incorporated into the CBT competencies explicitly. Little research has been conducted to investigate how and whether the IAPT programme approach to competence and training leads to cultural competence in therapists. Research is warranted into how CBT therapists accommodate culture in therapy and how the training programme has contributed to their ability to do so.

3. Study aims

A primary aim of the current study was to investigate whether the experiences of IAPT CBT therapists suggest that their clinical practice is consistent with what literature describes as culturally competent practice. This would provide insight into whether a more comprehensive cultural competency component is necessary to the training of therapists expected to work with BME clients. The research objective was to capture therapist feedback on the relevance and influence of culture in their clinical work, and capturing their approaches to, and experiences of, delivering CBT to BME clients. Data could be examined for consistency with cultural competency literature, and for any barriers to achieving cultural competency. Emergent inconsistencies or barriers would provide insight into what may be required to improve cultural competency of therapists. The information would also provide preliminary insight into whether the IAPT CBT competencies approach was effective.

A further aim was to understand how therapists considered IAPT training to have informed their work and contributed to their professional development. Feedback could inform training programmes and the curriculum.

4. Method of inquiry

4.1 Design

The study adopted a qualitative approach to achieve the exploratory aims of the study. Quantitative methodologies were explored. Standardised measures that allowed clients to rate therapist competency were considered inappropriate given the amount of data already requested from clients as part of the IAPT protocols. Questionnaires issued directly to therapists were expected to introduce a bias if participants were commenting on, or rating, their own practice or competencies. A qualitative approach involving interviewing would serve to provide rich data about participants' views and experience of the influence of culture in therapy, about how they might modify practice, and about the impact of training.

Focus groups were chosen as the most useful method to capture data. Participants in a focus group at a given IAPT site would be acquainted with each other and have common experiences in training and practice. This would facilitate interaction thus allowing the participants to question each other and voice their reasoning. The researcher could capture any tensions evident in the discussion as well as capture individual perspectives. Also, focus groups could be conducted in multiple sites (IAPT services) and would highlight themes common to IAPT services rather than only those specific to one service. This would add weight to any recommendations flowing from the conclusions because the results could be construed as being more representative.

Semi-structured interview was adopted as the means to conduct the focus groups. Interviews were structured to draw out participant comment on the topics relating to the

area of investigation i.e. their views and experiences of doing CBT with BME patients, how they modify practice, and how training has influenced their practice. The flexibility of semi-structured interview would enable a focus on the topics of interest whilst allowing natural flow of discussion.

Data could be thematically analysed and emergent themes compared with a cultural competency framework based on contemporary literature. The framework was constructed by means of a literature review on practitioner cultural competence (Bassey, 2011) which generated a set of themes.

4.2 Participants

Eligible participants were practicing therapists who had undergone the IAPT CBT training programme since its inception and had undertaken assessment or intervention with BME clients. The experience of conducting at least one session with a BME client was considered sufficient for participation. This was because the instance of a client not continuing with therapy might provide valuable insight. BME client status would be inferred from the ethnicity data routinely collected by services (DoH, 2005). No criterion for inclusion or exclusion of participants on the basis of their ethnicity was imposed. To introduce any additional criterion in order to control participant inclusion (with a view to engineering therapist-patient combinations) was likely to diminish potential participants. This did introduce the possibility that participating therapists belonging to BME groups might be talking about therapy with a patient of common cultural influences to their own. However, this would be a rich source of data. Also, the main aims of the study, i.e. to explore views and experiences of cultural factors in therapy and training, were still valid.

Potential participants were identified through liaison with IAPT services across one whole geographical region. The study was limited to one region for practicality. Service Managers at each site were approached to identify whether therapists at the service had

received BME client referrals. Out of eight potential sites three had therapists who had received BME client referrals. The service manager at each of the three sites was asked to provide a list of all therapists who had conducted at least one therapy session with a BME patient. Across the three sites fifteen individuals were considered eligible to participate and were invited to take part. Potential participants were forwarded the Participant Information Sheet and introductory letter (see Appendix 1). Those eligible and willing to participate were asked to return the reply slip or email the researcher.

Twelve positive responses were returned across the three sites (five + four + three). Respondents were allocated to a focus group attendee list for each site. Of the potential twelve participants, two were unable to proceed by the time of the scheduled focus groups. Actual participants were therefore ten in total, constituting three focus groups (four + three + three), one group from each site.

Information that was considered relevant to contextualise the data and any interpretation, e.g. therapeutic experience, was collected from the participants. Details of the information can be found in Appendix 2.

4.3 The interview schedule

The interview schedule was created to facilitate discussion around key topic areas. The aim of the schedule was to capture data that would facilitate a comparison with cultural competency practice guidance. It was sufficiently structured to maintain focus on the key topics, but not so rigid around the theory that discussion was overly directed and naturally emerging themes suppressed. Parsimonious use of questions relating to each topic facilitated discussion rather than direct answers.

The schedule was devised by reflective discussion with an academic supervisor and progressive revision. A revised version was piloted with a Clinical Psychologist who was experienced in carrying out CBT with BME clients. The schedule was subsequently revised

to form the final version (Appendix 3). The schedule contained four key topic areas: 'Relevance of culture', 'Doing CBT – responses to cultural influences', 'Working sensitively', and 'Training'. A fifth component consisted of questions to elicit participant reflections on the process. This was to aid the researcher to reflect on the research process.

4.4 Materials and resources

One researcher assistant was recruited to help facilitate the focus groups. The main researcher conducted the interview and focused on content. The assistant facilitated the process by managing time, ensuring the schedule was adhered to, and operating the equipment used to record the interviews. Audio recording equipment was hired to capture the data. Meeting rooms were sourced at each site.

4.5 Procedure

All interviews were arranged at meeting room facilities at the base of work for participants in each service. Participants were asked if information on the Participant Information Sheet was understood and were given the opportunity to ask any questions. The Participant Information Sheet (Appendix 1) provided information on:

- The purpose of the study
- What participation involved
- Informed consent
- Confidentiality and anonymity
- Potential for distress
- Benefits of taking part
- Use of findings
- Ethical approval

Participants were asked to provide consent (see Appendix 4), and to indicate whether they wished to receive the final report.

Audio recording equipment (set up prior to the interview) was used to record the interview. A sound quality test was carried out before the interview started. Each participant was assigned a participant number and asked to say "Participant #" so that accurate transcribing was possible.

The interview process was conducted according to the Interview Schedule (Appendix 3) and lasted two hours. Introduction and consent was followed by twenty minutes devoted to each of four topic areas. A ten minute break was scheduled at the halfway point. After the participant reflections were completed the interview was closed. Participants were given another opportunity to ask any questions before they left. The researcher and assistant researcher then recorded their own reflections on the session.

Each audio recording was transferred to an encrypted memory stick and transcribed for analysis. Names and places were removed from the transcript.

4.6 Ethical considerations

The study proposal was approved by an NHS Regional Ethics Committee and by Research and Development departments at each of the sites.

4.6.1 Confidentiality

Participants were informed that any identifiers, e.g. consent forms, would be stored securely and not shared unless potential harm to others became evident over the course of the research. Recordings were be stored on encrypted memory sticks until transcription after which they were destroyed. Any identifiers were removed from transcriptions.

4.6.2 Participant distress

As discussion about matters relating to ethnicity and race can be sensitive, measures were taken to support any of the participants who might become distressed. Time was reserved at the end of the interviews so that the researchers could deal with any issues, and professional supervision and support arrangements for participants were confirmed in advance with the Service Managers.

5. Analysis

5.1 Analytic method

Template Analysis (TA; King, 1998) was adopted as the most appropriate method for the analysis. TA can be used to thematically analyse textual data. It allows the researcher to organise data in a meaningful hierarchy of broad and narrow themes by means of a coding template. The coding template is produced by an initial thematic coding of a subset of the data. Themes are generated on the basis of significance to the research questions and not simply on quantity of data supporting a given theme. Parallel coding is permitted, i.e. the same section of text can be coded under multiple themes. The template is then used to code the next data subset and revised, i.e. new themes added and the hierarchy modified as necessary. The template is then used to code the whole of the data. The final coding template can be used as a basis for interpretation and for presenting results.

TA was selected over other forms of thematic analysis for four key reasons. Firstly, TA can be used to analyse textual data from a range of methodological and epistemological positions; it is not inconsistent with the realist-oriented position of the study (see Appendix 5). Secondly, TA lends itself to the introduction of *a priori* themes into the analysis, i.e. themes strongly expected to be relevant to the analysis, whilst not precluding the possibility that new themes may emerge. Given the established themes likely to be relevant to the data (from the cultural competency literature), it was pragmatic to adopt a method that allowed

themes from contemporary theory to be accommodated in the data analysis. Thirdly, TA emphasizes hierarchical coding of data, i.e. broad themes encompass successively narrower ones. Themes in the data could therefore be organised parsimoniously to accommodate both *a priori* and emergent themes. The method would avoid the creation of alternative labels (because of, for example, semantics) for themes that already have a label. Fourthly, TA is flexible technique that allows the researcher to tailor the analysis to match their requirements. In the current study there were only three extensive transcripts. The researcher was able to revise the template after each application to a transcript and arrive at a final coding template that reflected a thorough analysis of the data.

The TA method thus allowed the researcher to interpret data collected from participants in light of contemporary theory, and to identify factors relating to cultural competence that may be influenced by the training which therapists undertake.

5.2 Quality assurance

Quality of the research as a whole was maintained through transparency, i.e. by being explicit about the assumptions made and the methods and procedures adopted (Seale, Gobo, Gubrium, & Silverman, 2004). The selected research method was systematically applied according to its protocols, and quality checks recommended by its proponents were also adopted (King, 1998).

5.2.1 Quality checks

TA recommends the use of an outside 'expert' to scrutinise the analysis. Expert, in this context, means someone who is knowledgeable about the methodology and/or the subject matter. In the current study the assistant researcher became sufficiently familiar with the theory and rationale underpinning the research, as well as the approach to data collection. This was due to numerous discussions about the area of investigation, namely cultural competency, and through (as the focus group facilitator) necessarily needing to

understand the interview process and content. The assistant was also familiar with qualitative approaches to research. The assistant was therefore asked to review the coding, templates and interpretations generated by the researcher.

5.2.2 Reflexivity

Throughout the research process the researcher attempted to remain reflexive and consider his involvement in the process and how it can influence the course and outcomes of the research. This involved considering how personal beliefs, values and assumptions influenced the process and, in particular, the data interpretation. This was aided by reflective comments provided by the participants and the assistant after each focus group, and by returning to reflections of the researcher (recorded after each focus group).

5.3 *A priori* codes

Several themes were identified in the literature as significant to practitioner cultural competency. Themes were taken from an independent literature review conducted by the researcher (Bassey, 2011). The review focused on practitioner cultural competency as it relates to all psychotherapeutic practice. Techniques or approaches associated with a specific modality were not included. As the focus of the current study related to practice of CBT therapists, additional themes were taken from the emerging literature on CBT practitioner aptitudes[1], specifically the work of Hays (2010). It was anticipated that for the initial coding template these themes would form the higher level codes and that codes emerging from the transcript would form the lower level codes. An initial organising framework was therefore acquired through *a priori* themes. As the analysis progressed the *a priori* themes could be dropped or hierarchically reorganised with each application of the coding template to a dataset. 'Training' was an explicit area to be explored and was

[1] As stated in the introduction, much of cultural competency research relating to CBT has focused on the 'treatment' rather than the aptitudes and characteristics of therapists. However, some researchers have begun to shift focus towards the latter, e.g. Hays (2010).

therefore introduced as a higher level code. *A priori* codes to be incorporated into the initial coding template are shown in Figure 1.

Figure 1: *A priori* codes taken from cultural competency literature

Level 1 codes	Level 2 codes	Level 3 codes	Source
Awareness	Awareness of 'self'	Multiple identity factors	Collins & Arthur, 2007; Sue D., 2001; Sue, Arredondo, & McDavis, 1992.
		Own values/assumptions	Eleftheriadou, 2002; Lopez, 2006; Lopez, 1997; Pedersen, 2001; Sue, Arredondo, & McDavis, 1992.
		Capacity to think/act prejudicially	Collins & Arthur, 2007; Ponterotto & Pedersen, 1993; Ridley, 1995.
		Values that underpin cultural competence (personal and professional)	Collins & Arthur, 2007; Daniels, Roysircar, Abeles, & Boyd, 2004; Toporek & Reza, 2001.
		Assess self-development	Campinha-Bacote, 2002; Toporek & Reza, 2001.
	Awareness of 'other'	Multiple identity factors	APA, 2003; Daniels, Roysircar, Abeles, & Boyd, 2004; Hays, 2001; Lago, 2006; Lee, 2006; Macdougall & Arthur, 2001; Sue, Arredondo, & McDavis, 1992.
		Relations between client and therapist groups	Collins & Arthur, 2007; Cross, Brazen, Dennis, & Isaacs, 1989; Lo & Fung, 2003; Sue S., 1998.
		Feelings/beliefs associated to stereotypes	Cross, Brazen, Dennis, & Isaacs, 1989; Sue S. , 1998.
		Accept, respect others' beliefs/values, but change if necessary	APA, 2002; Sue, Arredondo, & McDavis, 1992.
		Avoiding over-emphasis on difference; holding on to commonality	Lo & Fung, 2003; Stuart, 2004.
	Awareness of social/political context	Recognise social, economic, political forces that may be relevant to client	DoH, 2003; Sue D., 2001; Sue S., 1998; Sue, Arredondo, & McDavis, 1992.
		Internalised messages of e.g. racism, ageism, sexism	APA, 2003; Collins & Arthur, 2007; Daniels, Roysircar, Abeles, & Boyd, 2004.
		How social structures impact mental health and help-seeking	Collins & Arthur, 2007; Lo & Fung, 2003; Sue S., 1998.

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Knowledge	Generic knowledge of cultural encounter	Seeking out knowledge	Cross, Brazen, Dennis, & Isaacs, 1989; Sue, Arredondo, & McDavis, 1992.
		Knowledge of differences in values and philosophical orientation that may exist between host and originating cultures	Berry & Sam, 1996; Fernando, 1991; Krause, 1989; Laungani, 1997; Lo & Fung, 2003; Nadirshaw, 2009; Sue, Arredondo, & McDavis, 1992.
		Impact of cultural factors on formulation/conceptualisation and solutions	Collins & Arthur, 2007; Fernando, 1991; Krause, 1989; Nadirshaw, 2009.
	Group-specific knowledge	Knowledge of traditions, values, beliefs, practices, help-seeking behaviours, communication styles, risk factors	Cross, Brazen, Dennis, & Isaacs, 1989; Daniels, Roysircar, Abeles, & Boyd, 2004; Nadirshaw, 2009; Sue, Arredondo, & McDavis, 1992..
		Acquisition by contact with group members	Alberta & Wood, 2009; APA, 2003; Campinha-Bacote, 2002; St. Clair & McKenry, 1999.
Skills	Skills relevant to communication and language	Use of interpreters	Blackwell, 2005; Lago, 2006; Patel, et al., 2000; Stuart, 2004; Sue, Arredondo, & McDavis, 1992; Tseng, 2004.
		Sending/receiving verbal and non-verbal messages accurately	Cross W., 1995; Gumperz, Jupp, & Roberts, 1981; Hall E. , 1976a; Lago, 2006; Lo & Fung, 2003.
		Language use and concepts	Leong, 1997; Lo & Fung, 2003.
	Skills in building the therapeutic relationship	Sensitivity to norms and identities	Collins & Arthur, 2007; Sue, Arredondo, & McDavis, 1992; Sue & Torino, 2005
		Therapist credibility	Comas-Diaz & Jacobsen, 1991; Sue & Zane, 1987.
		Curiously exploring client culture	Alberta & Wood, 2009; Pedersen, 1991; Sue, Arredondo, & McDavis, 1992; Sue & Sue, 1999.
	Skills in reaching a shared understanding	Attending to culture from the outset	APA, 2003; Macdougall & Arthur, 2001.
		Gathering culturally relevant information	
		Distinguishing between intrapsychic stress and stress from social structure	Cross W., 1995; Sue, Arredondo, & McDavis, 1992.
		Testing hypotheses	Sue S., 1998
		Co-constructing narrative through integration of perspectives	Alberta & Wood, 2009; Bhui & Singh, 2004; Lopez, 1997.
		Modifying theoretical concepts and philosophical	Leong, 1997; Tseng, 2004.

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		orientations to accommodate alternative word views	
		Drawing on group knowledge and relating it contextually to the individual	Sue S., 1998
	Incorporating appropriate strategies/goals	Consistency with the orientation and abilities of the client	APA, 2002; Sue & Sue, 1999.
		Accommodating alternative views of 'normality'	Lo & Fung, 2003; Tseng, 2004
		Establishing expectations of therapy	Sue & Sue, 1999; Tseng, 2004.
		Identifying culturally related strengths and supports	Lo & Fung, 2003; Nadirshaw, 2009.
		Building skills to interact more effectively with the social/physical environment and minimise stress	Lo & Fung, 2003.
		Modifying approach to goal acquisition – (directiveness)	Tseng, 2004.
		Question the helpfulness of thoughts/beliefs rather than their validity	Hays, 2010.
		Avoidance of challenging core beliefs	Hays, 2010.
		Create culturally congruent tasks/homework assignments	Hays, 2010.
Training			(introduced by the researcher)

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5.4 Creating the template

All transcripts were read before the initial stage of coding. A transcript was randomly selected to create the initial template (transcript 2). The data was analysed by assigning *a priori* codes to themes or generating new codes for themes emerging from the data. An initial template was therefore created by combining *a priori* and emergent codes. At this stage the unsupported *a priori* codes were not removed. This was so that significant themes emerging in subsequent transcripts could be aligned with *a priori* themes if appropriate. The template hierarchy was reorganised to best represent the scope and order of themes. Similar themes were collapsed into one theme and codes were reordered and renamed to parsimoniously represent the data. The revised template was then applied to the next transcript (transcript 1). The same process was adhered to for the final transcript (transcript 3). After the final transcript was analysed, *a priori* codes that did not have data to support them were removed and the template was again revised. The final template was then used to recode all the transcripts Appendix 6 shows an example of the evolution of themes over the course of the analysis.

Presentation of analysis under thematic headings is recommended by Burman (1994) and is often adopted in TA (see King, 2004). The final coding template served as an organising framework that would facilitate presentation and interpretation of the results and enable focus on the area of inquiry. Extracts from the final template are shown in the Thematic analysis section under each major theme.

5.5 Thematic analysis

The following is an account of the data organised according to the final coding template. The major themes are: *awareness*, *knowledge*, *skills* and IAPT *training*.

5.5.1 Theme One: Awareness

Figure 2: Hierarchy of themes under the major theme of 'awareness'.

Level 2	**Level 3**	**Level 4**
Awareness of 'self'	Own values/assumptions	Reflection on own worldview and culture
		Personal/professional life experiences
	Capacity to think/act prejudicially	Tendency to stereotype
		Beliefs/assumptions as obstacles
	Relation to equality/ diversity values	
Awareness of 'other'	Multiple identity factors	
	Relations between client/therapist groups	Sensitivity to 'difference'
		Greater attention to culture with BME clients
		BME group(s) relations to service(s)
	Feelings/beliefs associated to stereotypes	Individual context
		Dyadic cultural dynamic
	Avoiding over-emphasis on difference; holding on to commonality	Discerning relevance of 'difference'
		Not assuming difference
		Utility of universal concepts
Awareness of social & political context	Recognising social structures relevant to the client	Values implicit in model affecting the client
		Discussing effects of therapy with the client
		Responsibility for the effects of therapy

5.5.1.1 Awareness of self

Participants demonstrated a consciousness of beliefs, values and assumptions that they may hold as a result of their own cultural background and worldview, and expressed a need to reflect on them in order to maintain an open and flexible orientation toward the client's position and experience.

P2:..., I reflect more about it, its experience and reflection isn't it? That really gives you the kind of understanding about what kind of impact your culture has and they can just allow you to be flexible with that other person's experience

P3: So knowing, so knowing ourselves hopefully as well...

- FOCUS GROUP 2, LINES 958-962

P2: Yeah, I think sometimes it, it can be quite difficult. One client I saw, was really pleased that she'd kind of been allowed to go to University. [...] *And from kind of my background actually having to kind of ask permission for something is* [...] *obviously quite, quite a different kind of thing to sort of happen.*

- FOCUS GROUP 1, 281-287

A growth in awareness of the influences of culture was attributed to both personal and professional experiences. Such experiences led some participants to reflect on the values that underpin cultural sensitivity (equality, respecting diversity etc.) and to consider the relevance of those values to personal life and professional practice.

P1: ...you have to go through a process of erm, sort of readjusting your view of the world because you're meeting people and you're taking on you know, sort, erm sort of accommodate those new beliefs into what you understand, you know.

- FOCUS GROUP 1, LINES 1133-1136

P1: I think for me it's working in mental health generally but erm life experience as well. I mean obviously that comes into it cos you get it in the family, you get people coming up to you and talking to you, [....] *so you learn how to deal with that and you develop skills with working with people from your own background sort of thing erm but generally mental health, that's what actually triggered me in, going into mental health. There was one incident when I was like a nursing assistant and how that Asian woman was dealt with, you know was very er wrong. It was doing something that was culturally acceptable in the community but*

she, so that, but the way the nurse dealt with it wasn't right so, and that triggered me into thinking I need to do this cos I need to be there for...

- FOCUS GROUP 3, LINES 524-534

Participants were aware of how their own beliefs, values and assumptions could constitute a barrier to understanding their client. In particular they were aware of their own tendency to draw on group stereotypes, i.e. to make assumptions about an individual based on their identification with a cultural group. This was viewed as something that could impinge upon the practitioner's ability to understand the individual client's experiences. Many participants monitored themselves in clinical practice in order to adjust perspectives that may have been influenced by stereotypes.

P2: I think about erm what I think I know about the group and my stereotypes so, I kind of tell myself early on to watch my stereotypes and you know, that this person going to come in as an individual, erm maybe with some features you know, that they, some aspects of the culture that I imagine but not necessarily all of them, so just reminding myself ok, this is a culture I know; this is what I know about this culture but this person's an individual so, what, whatever'll be there, kind of cultural appreciations really.

- FOCUS GROUP 2, LINES 109-115

5.5.1.2 Awareness of 'other'

Participants expressed an awareness of the multiple identity factors that a client can have (ethnicity, gender, age etc.) and their potential relevance to the therapeutic encounter.

P3: ...if I get a referral and you know sometimes I might look at the gender as well and I sort of think, you know, how that might affect it, in that particular culture or just to think about

what, yeah what that particular group, what I know about that group and whether that's going to be relevant and the age of the client as well and erm you know whether that might make a difference

- FOCUS GROUP 2, LINES 117-125

P3: ...I'm very mindful as well that you know obviously they're not just people from the BME community but also erm you know kind of like the age gap as well.

- FOCUS GROUP 3, LINES 317-319

Many participants made statements that reflected sensitivity to the difference dynamics that could exist between therapist and client. Whilst difference was acknowledged as relating to various dimensions (age, gender etc.), work with BME clients often led to a greater consideration of cultural influences by the therapist. For some participants this included a consideration of commonly held views by BME communities about mental health services. Some paid attention to a client's feelings/beliefs associated with the cultural dynamic in the dyad, and explored these openly with the client.

P4: It's about kind of like, if it was an Afghan client, you don't know much about that person and it's about under, so whatever maybe we have a better understanding or an assumption of a better understanding of the class system and how you know, it's a Western, White Western kind of world but perhaps I suppose we make assumptions there really as well, but maybe we make more of an effort to find out what the other cultural differences and what that impact is maybe. I don't know.

- FOCUS GROUP 1, LINES 335-340

P1: Yeah, I think you do. I mean you know, there are some and I don't think it's always necessary but I think there are some sort of erm patients or clients that if you basically do a you think there., there is some, it's like, a white elephant in the room.

P3: Mm

P1: It's like, ok, you need to kind of bring that into the room so that you can talk about it so that it is kind of, break the ice cos they're almost, and sometimes it's not necessarily about them, it can be about you, as you say.

- FOCUS GROUP 2, LINES 210-216

A resistance to over-emphasis on difference, and the need to hold on to common human understandings and experiences, came across in the comments of some participants. Many stated that the relevance of difference should not be assumed, and that differences may or may not be relevant to the therapeutic encounter. To focus on universal or common concepts rather than necessarily cultural differences was perceived by some participants as being more helpful.

P3: He didn't have to even bring it up, it felt such a universal experience of abandonment and loss and now his inability to have his own sense of you know, erm agency I guess. You know to be able to get on with his life and; the culture didn't seem

I: And did it erm, as the sort of therapy erm progressed, did it stay that way or did you find that there was sort of erm moments where his cultural background...

P3: Yeah, I think, I think it will come up. I mean I'm still seeing him. I think it will come up erm and they are obviously there but I think the universal sense of loss and abandonment was very much you know just what we all were working with really.

- FOCUS GROUP 2, LINES 270-277

P4: [...] *I had a client who attended with a hijab and so I thought she's going to be quite worried sitting there er, a white man and it was fine, it wasn't an issue and we actually had a very good therapeutic relationship and it never seemed to be a problem so just proved me wrong into jumping into conclusions about the background*

- FOCUS GROUP 1, LINES 482-486

5.5.1.3 Awareness of social/political context

Participants made statements that suggested recognition of how social forces (e.g. family structures and traditions, social convention) may be relevant to the client's presentation. Some participants were also conscious of the impact that intervention can have on a BME client's social functioning in their environment, due to values and attitudes implicit in Western therapies.

P3: Mm. Yeah. I mean the guy that I see with the OCD and the responsibility issues we've been looking at kind of roles; who is responsible for what really and it was interesting cos we looked at his role, his wife's role. He lives with his mum and two children and he didn't put down that, the relationship with his wife or spending time with his wife was important nor the other way round for his wife; it was more about he needs to be there for his sisters, the wider family, his mum. He needs to be a rock.

- FOCUS GROUP 1, LINES 268-275

P2: What about the consequences of how that plays out in their cultural environment though? So if you socialise somebody to be very, very kind of independent and you're encouraging that but then they go back out into their environment, how's that going to play in their environment?

- FOCUS GROUP 2, 842-845

Some participants stated that to discuss the impact of therapy on a client's social functioning was an area that required particular attention for BME clients. However, others took the position that this was a necessary consideration for all clients and BME clients did not necessarily need any special attention in this regard. The responsibility for the impact of intervention on a client's functioning in a given environment rested with the client as long as the therapist had helped the client to consider the implications.

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P1: [...] *but then you're then taking responsibility for their behaviour. If they want to be more assertive and they've come to you and want to be more assertive, then them going back into their environment and being more assertive then (pause) you know what happens in their; they know their culture, they know how that's going to be responded to by their culture, the same as I would you know if I turned round to my grandmother and sort of was very, very you know assertive with her. I know exactly what I'd get; do you know what I mean?*

P2: Yeah. You could be mindful.

P1: Absolutely. Exactly, you know they know their culture. I mean they're the best person to know how that kind of behaviour is going to be responded to within their culture.

P2: Yeah

P1: That doesn't mean that you shouldn't teach them, if they want that. Teach them assertiveness techniques but that means that they are then going to decide how they're going to use them.

- FOCUS GROUP 2, LINES 850-864

5.5.2 Theme Two: Knowledge

Figure 3: Hierarchy of themes under the major theme of 'knowledge'.

Level 2	Level 3	Level 4
Generic/theoretical knowledge of cultural influences in therapy	Seeking out knowledge	Acquisition by community contact
		Acquisition through research
	Practitioner development	
	Worldviews implicit to the CBT model	Discerning congruence of model/ client worldview
		Flexibly applying the model
	Knowledge of differences in worldview & philosophical orientation between cultures	Responsibility for knowledge
		Understanding impact of acculturation
Group-specific knowledge	Knowledge of traditions, beliefs, practices, help-seeking, risk factors	Utility of background cultural information
		Concepts of illness
		Lack of knowledge as a barrier
		Knowledge as an aid to contextualisation
		Knowledge helps to identify common group needs
		Knowledge acquired through the client
	Acquisition through contact with group members	Engaging agencies/institutions

5.5.2.1 Generic/theoretical knowledge of cultural influences in therapy

Some participants advocated a personal exploration of the potential differences in worldview and philosophical orientation that may exist between cultures (such as Western and other cultures). To understand the impact of acculturation and how alternative worldviews fit with the CBT model was considered useful to practice, in that it facilitated flexible application of the therapeutic approach to clients. It was suggested that generic knowledge could be acquired through research, conferences and contact with the community, and that therapists could become accustomed to accommodating culture.

P2: ...the sociotropic view that Beck has, and he talks about individuals being more autonomous or more sociotropic and it'd probably be interesting to get feedback from the culture itself about where does that fit into their model and their thinking really. How much do we need to take that into consideration and that sounds rather theoretical but on a, on a larger, on a more individual scale when I've worked with people who actually want to, especially in this country where there's kind of people, there's kind of children who are you know first generation; they're born in Britain but they're actually, their culture is of another, is of another country erm they're trying to experience both of those cultures and some of its fighting against the conformances of their own, of their own culture.

- FOCUS GROUP 2, LINES 712-720

P2: Also talking about mindful, erm you know there does seem to be a shift between CBT and maybe erm you know, the CBT seems practically very Westernised, very scientific, rational thinking, that kind of er ethos and, and then you've got er other cultures that come from perhaps the East which are much more erm whole body experience. Not so much in the head but in the body and physiology so they incorporate a more holistic view of their health which I think erm CBT seems to be catching on a bit with this mindfulness thing.

- FOCUS GROUP 3, LINES 202-208

5.5.2.2 Group-specific knowledge

Participants expressed differing views on the utility of knowledge about specific ethnic groups. Some stated they found it useful to acquire cultural knowledge (traditions, practices, beliefs, common words, concepts of illness, common health needs) about sub-groups of the community they work amongst. Such knowledge was viewed as a background which helped to contextualise the individual's comments and experiences. To acquire such

background knowledge some participants engaged in contact with social and religious institutions.

P4: I suppose it gives you a template to use in reserve, knowledge as in ok so I could say for example that I've got an Asian client. She may have these commitments to her family; she may go Diwali, maybe this. Wait and see until you meet the person; it gives you that, I guess that background knowledge

- FOCUS GROUP 1, LINES 1268-1271

P2: [....] *I think I was completely kind of unaware of particular backgrounds and, I wasn't informed about it in my classes or anything so I went to the community centre and asked for a history of the culture and they were able to provide me with that so I just, it was just a bit more, I was a bit more aware of what had happened in the culture*

- FOCUS GROUP 2, LINES 150-157

Some participants took the position that prior knowledge about specific groups was not essential to the task of therapy, and could serve to introduce inappropriate generalisations and stereotypes. It was argued by some that to place the onus on the therapist to know about the client's culture was impractical and that cultural issues relevant to the client should and could be raised by the client. Others suggested that it was better to not enter into a therapeutic encounter with assumptions, and that relevant cultural information could be acquired through a given client, whilst further information could be gathered outside of the therapy if specifically required to meet the needs of the client.

P1: I think, I mean I well I suppose getting back to my sort of personal view is I think you work with the individual; I think you work with what comes through the door and if there

are, you know there are cultural impacts, if there are those things then you, then you deal with them you know. We should kind of go along, the same as you would if, you know if one person came in late, cultural impacts from their background and childhood or things that they've been through you know when they come up, if they come up you would manage and you deal with them as you go along. If they need to be engaged with, you engage with them. If they're not, you know.

- FOCUS GROUP 2, LINES 830-841

P2: I don't think you can make yourself learn for the sake of it. I think if I saw somebody and they said I'm from Bangladesh and I don't know anything about Bangladesh then I would ask them what they know about it and then it might trigger an interest for me to read up about sort of what they'd said. I mean I, I came across some guy that er had been ran over; deliberately run over by somebody erm in Sudan that, that he'd fallen out with and he got to talking to me about the differences between North Sudan and South Sudan and I, I then went home and started reading up about it cos I you know, I thought I don't know anything about this.

- FOCUS GROUP 3, LINES 630-638

5.5.3 Theme Three: Skills

Figure 4: Hierarchy of themes under the major theme of 'skills'.

Level 2	**Level 3**	**Level 4**
Communication and language	Use of interpreters	Pre-engagement consideration of language
		Therapist-interpreter relationship
		Client-interpreter dynamic
		Effects on communication quality and tasks of therapy
	Language use and concepts	Teaching theoretical concepts
		Functional/conceptual equivalence
Building the therapeutic relationship	Sensitivity to norms and identities	Curiosity about client culture
		Relevant cultural issues learned from the client
		Flexibility in boundaries
	Therapist credibility	Credibility assumed by client
		Re-allocation of power
Reaching shared understanding	Attending to culture from the outset	Explicitly exploring cultural issues/variables
		Managing client expectations of therapy
		Allowing client to articulate aims
		Considering alternatives
		Questioning to evaluate suitability of the model
		Allowing client to feedback what is important
		Discerning when to raise cultural issues
	Gathering culturally relevant information	Client feelings about the dyadic cultural dynamics
		Drawing on own experiences
	Co-constructing narrative through integration of perspectives	Distinguishing between intrapsychic stress and stress from social structure
		Testing hypotheses
		Space to reach shared understanding
		Time to reach shared understanding
		Challenge of accommodating worldviews/perspectives
		Client integration of the model
		Therapist recognition of limitations of model
Incorporating strategies/goals that match client abilities/ orientation	Modifying structure, content, and pace	Communication difficulties impact on structure and pace
		Accommodating alternative views of normality
		Institution not supporting therapists
		Avoidance of challenging core beliefs
		Modifying approach to goal acquisition (directiveness)
		Consistency of goals with standardised measures
	Tailoring of strategies/goals not different on the basis of ethnicity	

5.5.3.1 Communication and language

The client's spoken language was a primary consideration for many participants when referred a BME client. To use the same interpreter throughout an intervention and to build a relationship with them was considered an aid to effective communication. Some participants expressed the need to be sensitive to the culturally influenced dynamic that can exist between clients and interpreters. Many viewed the use of interpreters as impinging upon the quality of communication and consequently making the process of therapy more difficult.

P1: ...I've had a Bosnian client and the only interpreter I can get is Serbian interpreter and erm that has caused problems and in the end the lady dropped out of therapy.... She didn't trust the lady so she wasn't able to kind of speak about what she wanted to talk about. Again, it was about trauma, it was about you know she didn't want to recount and relive those sort of experiences in front of er a Serbian lady.

- FOCUS GROUP 2, LINES 142-149

P1: There's also I find that if you're using an interpreter, things like the erm the therapeutic alliance, forming alliance, is that forming alliance with the interpreter, not you? Because obviously the eye contact's there, the emotion's there, you know I don't understand exactly they're saying so you, you, I do find that it forms you know, you're sort of doing it by proxy almost

I: Yeah

P1: Sort of supporting the interpreter almost to do the therapy rather than doing it

P4: With some interventions I er avoid it, because you know I'm thinking of PTSD work of 'reliving'

P2: Mm

P4: And I wouldn't use an interpreter for that intervention because it's not going to offer the synthesis that it needs. It has to be that they offer a narrative and then, they put, if you did you're putting the interpreter in the role of the therapist which isn't healthy because they've not got that experience so...

- FOCUS GROUP 1, LINES 359-374

The ability to teach the client some theoretical concepts that are fundamental to the CBT model was viewed as a necessary skill for working with some BME clients.
Some participants also described exploring language use and concepts. This included exploring and accommodating culture-specific phenomena and expressions of distress.

P1: I had one client who, she's had doctor after doctor after doctor all saying there are symptoms of anxiety

P3: Yeah

P1: And she's like no, it's not anxiety, it's a burning pain, it's this, that and the other

P3: Yeah

P1: And erm, with that I know that the GPs are getting quite exasperated because they, there's nothing physically wrong

P3: Yeah

P3: But they don't know what that means, I think that, you know when there's that, like you said, that borderline when you don't quite need an interpreter but then what you're saying they're not quite grasping or what they're saying you're not quite grasping

P2: Mm, it takes a lot longer

- FOCUS GROUP 1, 600-613

5.5.3.2 The therapeutic relationship

Many participants stated that a therapeutic alliance could be fostered and maintained by curiously exploring what was important to the client; thereby allowing any culturally relevant issues to emerge during this process.

P2: Well, I think my stance is when I see somebody from a BME background I try and, I suppose its empathy. I'm trying to put myself in their shoes and I guess I, I don't say it this way but I kind of plead ignorance and say you know I'm not sure er, perhaps you can tell me, inform me what the problem is from your perspective, from you know, not just your perspective, your family, your culture. Is there anything I need to know so I'm kind of coming in quite green and asking them to inform me and then I'll try and say what I've got that maybe can erm fit with the way they see things.

- FOCUS GROUP 3, LINES 231-238

Flexibility in the application of boundaries appeared to be helpful in maintaining the relationship. Participants stated that some BME clients often wanted to know about the therapist's personal life. This was a cultural norm that facilitated trust. The therapist had to consider what was appropriate to share in order to nurture the relationship.

P3: ... You know Hindus, they're very, how many children? Are you married? You know, do you live with your in-laws? And..

I: Right

P3: And it's very difficult to kind of, well you try and not to share something about yourself and you think well this is about you, not. If it wasn't relevant in that context, I think you know, Asian people it's just a normal thing to ask isn't it?

P1: I find sometimes it does help to give a little bit of information. Yes, I've got children.

- FOCUS GROUP 1, LINES 684-692

Some participants expressed that with many BME clients the credibility and authority attributed to therapists prior to engagement could hinder the working relationship, and efforts to reallocate power to the client were often necessary.

P3: But it's like you're the person; you're not just a therapist that's carrying out a therapy; you're the be all and end all that'll sort out all their problems and sometimes it will get you involved with different; they want you to get involved with doing other things then that boundary actually needs to be very clear you know

- FOCUS GROUP 1, 782-785

5.5.3.3 Reaching a shared understanding

Participants described different approaches to reaching a shared understanding of the client's perspectives and difficulties. Some would proceed 'as usual' and seek to identify from the client's feedback when culture was relevant to the content and process of therapy. Others preferred to explore cultural influences from the outset, and how such influences might affect expectations of therapy. This might be done explicitly by asking the client questions about their culture and allowing them to articulate what they hoped to get from therapy. Both approaches might involve gathering culturally relevant information throughout the intervention.

P3:...I saw a, a 58 year old Asian man recently and erm you know and immediately I sort of, we just kind of sat down together and I just thought I wonder you know how he really does experiences this moment with you know, me as a white sort of similar age kind of, well slightly younger (laughs) person you know; what that, what that means for him and so I just,

I just asked, I asked the question. I said you know how does it feel coming here you know to a woman erm you know in this kind of role you know and erm and it broke some kind of you know, broke the ice basically and he, yeah he kind of acknowledged that, that culturally that was, it was different.

- FOCUS GROUP 2, LINES 169-177

Some participants demonstrated sensitivity to the impact that culturally influenced social structures can have on clients' functioning and distress, and the need to test hypotheses about distress in order to reach a shared understanding of the problem. Participants drew on personal experiences to make sense of clients' experiences, and at least one participant described openly sharing their experience. To reach a shared understanding was viewed as a challenging task that involved the therapist making space or allowing opportunity for a client to express a problem in their own terms.

P2: Or not and if you can see that they're not well you can say well it doesn't feel like this is hitting the right mark for you. What, how, what do you make of it so I suppose it's drawing them in and trying to be collaborative to get them to help you to see the way they see the problem.

- FOCUS GROUP 1, LINES 425-428

To accommodate alternative worldviews and integrate client descriptions of a problem with perspectives implicit to the therapeutic model (such as diagnostic criteria) was viewed as a challenging task that could add time to the intervention. Some participants held the view that a client needed to be able to take on concepts implicit to the CBT model, such as the role of thought processes, in order for therapy to progress. However, others were more willing to move away from the model.

P1: ....I think CBT, there is a level of your not getting what you don't; some people just don't and I think that brings it back to that kind of mind, body link you know. If they don't kind of recognise that there is a thought process going on there and it does impact what is happening for them then they're not, just not going get it whatever.

- FOCUS GROUP 2, LINES 480-485

P3: I think it very much depends on who's sitting in front of you and what they bring in to the session. I think I've gone from the extreme of trying to kind of like explain to them what we do within the service to kind of like, just get on with it and work with what they've brought and that would mean just you know moving away from the CBT model.

- FOCUS GROUP 3, LINES 401-414

5.5.3.4 Incorporating appropriate strategies/goals

The need to potentially modify the structure, process, content and pace of intervention according to the culturally influenced orientation and abilities of the client was expressed by many participants. For example core beliefs held by clients that might relate to spiritual matters were not perceived as something to be challenged. Other participants recognised that communication barriers could affect the structure and pace of intervention, but held the view that content varied for all clients and culture was just one variable that affected content. Intervention process did not therefore necessarily need to change on the basis of BME membership. Institutional support for the extra time that might be needed was not perceived as good.

P3: If they, if they keep coming in, week in, week out with I've got this headache and I can't shift this headache and you've just got to work with, okay what can we do to make that headache easier

P1: Mm

P3: Rather than try and to go down the CBT route of rationalising things.

- FOCUS GROUP 3, LINES 272-277

P1: ....I always try and relate any sort of, if I'm trying to do anything with a model I basically always try and relate it back to them so basically I'll ask them to give me an example of something that's going on and then I take the model back to that ..... you've got to relate to something that's going on in their life and something that they're struggling with, something that they're finding difficult so I think you know that basically works with anybody really...

- FOCUS GROUP 2, LINES 470-478

P1: ...when you're talking about kind of the time we're given by managers and our targets and the fact that if we don't hit our targets then we don't get a pay rise and we don't get you know basically, they see us under achieving as therapists.

- FOCUS GROUP 2, LINES 533-536

Some participants were aware that goals agreed with BME clients were often not congruent with the standardised measures used to gauge progress. Also, the task of setting and reaching goals required attention to the balance of directiveness and respect. Respect for beliefs whilst maintaining the position that the intervention will require effort on the part of the client.

P1: Because otherwise that can be quite dangerous that they come in and you like with that belief, that religion thing that you know [C] will sort the problems out

P2: You cure me

P3: Yeah

P1: Before, I'm not here to cure you

P4: Collaboration addresses that doesn't it?

P2: Mm

- FOCUS GROUP 1, LINES 863-868

5.5.4 Theme Four: IAPT Training

Figure 5: Hierarchy of themes under the major theme of 'IAPT training'.

Level 2	**Level 3**
Content	Inattention to culture
	Cultural competence module option
	Orientation toward Western perspectives
	Consideration of how alternative worldviews align with the model
	Attention to how culture impacts on elements of CBT
Format and delivery	Incorporating reflective discussion/writing
	Video footage of therapy
	Access to 'experts'
	BME client feedback
	BME trainee feedback
	Placements in BME communities
Supervision	Use of supervision
	Insufficient space to reflect
	Discussion of cultural factors dependent on trainee motivation
Learning beyond training	

5.5.4.1 Training content

Participants had different experiences of the training programme's attention to cultural factors. For some there was no specific consideration of culture apart from a written assignment on the needs of BME communities. For others the cultural component consisted

of half a day of teaching on the traditions and practices of a specific BME group, delivered by a 'non mental health' individual. Neither was considered to sufficiently address how cultural influences are relevant to therapy. For some participants a cultural competence module was part of the programme, but it could be opted out of based on previous diversity training, and some participants did opt out. There was spare time which a trainee, if self-motivated, could use to learn more about the influence of culture in therapy.

P3: Well, it's a module so you know there was, there was time to do stuff ourselves you know which I did think, I did think quite a lot about it actually. It kind of brought up issues again for me about power I think, and, er and about race and about gender and about you know, people's history and, and backgrounds and the importance of that within a therapeutic relationship that, that need to be addressed I think or need to be talked [...] *about.*

- FOCUS GROUP 2, LINES 1183-1188

Comments about cultural consideration in training reflected certain shortcomings. Participants stated that there could have been more consideration of how alternative worldviews align with the theoretical positions implicit in the CBT model; the content was viewed by at least one participant as having an overly Western orientation. Participants also wanted to learn more about how cultural background can impact on the elements of CBT (assessment, formulation, therapeutic alliance, goal-setting etc.).

P2: So it wasn't sort of like you're saying you know where within CBT stages and do you feel that you know, different ethnicities is going perhaps cause difference, it wasn't anything
P3: I mean really, they couldn't have done their best. Could they? They could have

P1: Have a think about it, you know. How does that make you think and, you know have you changed your view by today? You know, what makes you change, you know the questions you ask would have been perfect for that session.

P3: I was going to say, that would have been perfect.

- FOCUS GROUP 1, 1545-1553

P3: [...] *It was woefully, woefully inadequate I think as a, you know. I mean I know they've tried to squeeze everything into the IAPT into a very short time to save money but I think that part of it was, was really skipped over* [...]*there was one module where we looked at supervision and diversity and we looked at ethics and we had a research proposal to do so that was, that sort of came in there very briefly but not really, not really thought about in terms of how we could adopt, adapt the model.*

- FOCUS GROUP 2, LINES 1152-1161

5.5.4.2 Format and delivery

Reflective discussions, reflective diaries, written assignments and visiting community institutions were mentioned as ways in which training could enhance the abilities of trainees to work in a culturally sensitive way with BME clients. BME trainees and BME clients were viewed as potentially a useful resource in terms of feeding back experiences of the training programme and experiences of engaging services. Video footage of therapy being conducted with BME clients and access to therapists with comprehensive experience were other suggestions for improving training.

P2: I would've liked to have seen a video of er some, some of the things we've been talking about today. Er how er a qualified experienced CBT working with an interpreter could do not just the assessment but ongoing work and, and just let them demonstrate how it's meant

to work in theory. [...] *Cos in reality we have to, we have to be pragmatic* [...] *and er I'm not sure CBT, when you're training anyway, advocates pragmatism you know. But er so I would like to see how it works in reality.*

- FOCUS GROUP 3, 752-758

5.5.4.3 Supervision

Supervision during training was considered by some to be a place where cultural issues arising in therapy could be discussed, but some participants found that sessions did not provide sufficient opportunity to reflect on culture. Obstacles included the fact that supervision sessions were often conducted in groups. Some participants felt that sessions were time-pressured and agenda driven rather than being a reflective space.

P2: Supervision, everything in CBT in my experience and it's a shame because I'm sure it shouldn't be like this, but CBT in IAPT anyway all feels very layabout. Sort of push and er keep going and erm and I think not so much in supervision but we still have three or four people in supervision for an hour and a half or something and you begin to get through and there wasn't the reflective space that you might get in other therapeutic gravities. Er it's very much get people through....so er I think the deficit of that approach is, is time to really reflect.

5.5.4.4 Learning beyond training

Participants expressed a view that much of the competency to work with diverse cultural groups is attained through clinical practice in diverse communities, and dependent on where a therapist works. Training was perceived as not being sufficient to prepare a therapist for the work.

P3: You see I think it's really important because I was just thinking if I worked in [L], there's a whole community of you know, do you know to have the level of training we've had and then to actually work in [L] would have been a huge learning curve to be honest. [...] *if you were looking at solely having this IAPT training and then working as a CBT therapist,* [in] *London, or whatever, you know,* [...] *you would actually not be competent to work with them really*

- FOCUS GROUP 1, LINES 1793-1812

5.5.5 Summary of the analysis

It was possible to maintain a structure to the template that was based on the higher level *a priori* themes, i.e. to locate emergent themes within the cultural competency framework. Emergent themes were positioned in the third and fourth levels of the template hierarchy. *A priori* themes that did not endure were from level three of the template. The level two theme 'Incorporating appropriate strategies and goals' was slightly modified to reflect an emphasis on modification to intervention structure, content and pace. 'Training' was a specific area of investigation and therefore constituted a new major theme. Sub-themes under training were found to be 'content', 'format and delivery', 'supervision' and 'learning beyond training'.

The results could be interpreted in terms of the way in which data fitted with the cultural competency framework, and in terms of the substance of the narrower themes.

6. Discussion

6.1 Summary of the findings

The results revealed a degree of consistency between the views and practices of therapists and what the literature describes as cultural competency. Themes arising from statements made by therapists fitted into a cultural competency framework encompassing

awareness, knowledge and *skills.* Therapists were conscious of how their own values, assumptions and tendencies were implicated in therapeutic encounters. They also demonstrated sensitivity to the dimensions in which difference could exist between themselves and the client, and sought to discern when cultural difference might be relevant in each individual case. Attention to the social environment of the client and its potential influence on client's distress was also evident. The utility of generic knowledge about culture as well as group-specific knowledge was valued by many therapists as a means to contextualise an individual's perspectives. Skills relevant to effective communication, building a therapeutic relationship, reaching a shared understanding, and incorporating culturally sensitive strategies and goals were also evident in the views and experiences of therapists. Therapists expressed a range of ways in which they modify interventions to accommodate cultural influences.

Some themes emerged from the data that reflected the efforts made by therapists to work sensitively with BME clients. Therapists paid more attention to the potential relevance of cultural factors when working with BME clients. More time could be spent exploring culturally relevant issues and also in communicating and adapting the intervention approach to meet the individual's needs. It was felt that services needed to acknowledge and make allowances for the added time that is required for culturally sensitive practice.

Whilst the themes emerging from the results of the interview data were generally consistent with those indicated in the cultural competency literature, there were some evident tensions that stemmed from different perspectives on what was required to meet the needs of BME individuals when doing CBT. These tensions bridged both 'technical' and 'ethical' domains. Technical tensions related to what approaches were necessary to be able to effectively apply CBT, whereas ethical tensions related to responsibilities associated with therapy.

The major theme of *training* revealed a range of views on the training experience, its contribution to the competency of therapists, and on how it could be improved.

6.2 Implications

6.2.1 Competency evident in therapists' views and practices

There was a high level of consistency between the practices of the therapists interviewed in this study, and the elements deemed to reflect cultural competency in the literature. This raises important questions about how that competency was acquired. For most therapists the training programme was not considered to have adequately addressed the issue of culture and its influence in the practice of CBT. The specific training programmes undertaken did not appear to cover cultural competency in the level of detail that is evident in the literature. For example, therapists would have liked to consider how alternative worldviews align with the theoretical positions implicit to the CBT model, and how culture can impact on the various tasks of therapy. Therapists attributed their acquired competency to personal and professional experience and a personal motivation to learn about the influence of culture in therapy. Professional experience for many therapists involved regularly engaging BME clients in mental health settings, and becoming acclimatised to therapeutic encounters where culture is relevant. The ten participants had a mean average of fourteen years experience in mental health. Their ability to conduct CBT interventions in a culturally sensitive way with BME clients may therefore be more attributable to experience and being motivated to develop rather than to training. Therapists expressed the view that cultural competency was enhanced primarily through experience of working with BME clients and that training alone was not sufficient to prepare them for the work.

Another explanation for the competency evident in the sample may be a combination of appropriate recruitment together with the overarching approach to cultural competency in IAPT CBT trainees (Roth and Pilling, 2007). In this framework cultural competency is

described as embedded in other frameworks such as the Ten Essential Shared Capabilities (Hope, 2004). Such policy documents emphasise the need to respect and work with diversity in all mental health practice. Recruitment to CBT trainee posts is likely to value mental health experience which in turn should mean exposure to the values and principles relating to equality and diversity that underpin all practice. Cultural competency may be engendered by the natural process of individuals allowing equality and diversity values and principles to shape their clinical practice of CBT. Intuitive adaptation of CBT to meet the idiosyncratic needs of an individual, which is generally what CBT involves, may be sufficient to also meet the culture-related needs of many BME clients.

Although therapists in the current study could draw on extensive experience and were likely to have been influenced in their practice by NHS values, many believed that their ability to work sensitively with BME clients could be enhanced by an improved training experience.

6.2.2 Improving the training programme

Training may be able to better prepare therapists to carry out CBT with BME clients by attending to the influence of culture in therapy. This objective could be achieved by revision to course content and format, and better access to supervision.

CBT trainees may benefit from a consideration of how some non-Western worldviews, values and attitudes align with Western ones and with the theoretical positions implicit in the CBT model (e.g. mind-body distinction vs. mind-body-spirit unity, free will vs. determinism, openness vs. restraint. See Fernando, 1991; Laungani, 1997; Schilling & Brannon, 1986). Reflection on how cultural influences might impact on the different stages of CBT (e.g. assessment, formulation, fostering the therapeutic alliance) was a part of the interview process which therapists viewed as a valuable exercise that could be incorporated into training. Reflective discussions, reflective diaries, written assignments, videos of therapy

being delivered, visits to community institutions and BME client feedback are practical suggestions drawn from the data on how to build cultural awareness, knowledge and skills.

Supervision is a valuable component of any therapeutic training yet access to space for trainees to discuss cases in detail appeared to be variable. There may be a range of reasons why this was the case. Some supervisors may not feel comfortable or competent to be able to discuss cultural issues with trainees. Additionally, a priority may be to ensure that the techniques of CBT as described in the curriculum are being learned and applied correctly. Supervisors may themselves feel under pressure to fulfil this obligation and this may have been why some therapists perceived their supervision to be time-pressured and agenda-driven. However to acquire cultural competency seems to, according to therapist feedback, necessitate a space to reflect on how culture might be relevant to a particular client.

6.2.3 Differing perspectives on approaches to client culture

Some tensions were evident in the findings that related to differences of opinion regarding CBT with BME clients and what ethical responsibilities rest with the therapist.

Different perspectives were held regarding the utility and acquisition of cultural knowledge, specifically in relation to knowledge about the characteristics common to a specific ethnic group. One position emergent from the data was that cultural issues relevant to a particular client could be determined in each specific case. This could be established through the therapist exploring cultural factors with the client and researching the pertinent cultural issues outside of therapy if necessary. It was argued that this approach was valid for multiple identity factors that may be relevant to any client's case (gender, class etc.) and not just BME clients, and that ethnicity as a variable did not require a different approach. To attempt to proactively build a knowledge base around a particular ethnic group was considered unnecessary, although knowledge would inevitably accumulate with experience. Prior generalised knowledge was also said to increase the likelihood of stereotyping and

making false assumptions about an individual. An alternative position offered by some participants was that lack of background knowledge was a barrier to understanding the individual, and that awareness of the traditions, beliefs, values etc. of a cultural group helped to contextualise the experiences of a client and facilitated shared understanding. Such knowledge could be actively sought through engaging that particular community; a view supported by the literature. The latter position is more consistent with the literature on cultural competency.

Different views were also evident in the necessity to strictly adhere to the CBT model. Some therapists had experienced situations where they felt that the model and CBT rationale did not work for their client. They described moving away from the some of the facets of the model and the structure typically followed, in order to more appropriately accommodate the client's needs. Others took the view that the client needed to take on theories implicit to the model, such as the role of thought processes, if CBT was to work. Neither approach is contrary to cultural competency practice guidance as long as in the latter situation the therapist is convinced that the client is able to work with the concepts.

Another tension related to responsibility for the effects of therapy. Therapists were generally conscious of the need to be aware of social structures relevant to a client, and how these are shaped by cultural influences. They were also aware that therapy can sometimes involve a client adopting behaviours that are associated with a Western value base. For example, a client might build assertiveness as part of the intervention strategy, and assertiveness may have negative repercussions in the client's social environment. Some therapists took the position that they might be reluctant to adopt such a strategy if they believed it was not in the best interests of the client. An alternative perspective was that as long as the potential repercussions have been considered and discussed, the client is then responsible for raising any potential difficulties and is and responsible for the outcomes of the therapy.

The above tensions reflect technical and ethical issues in conducting CBT with BME clients. The fact that these tensions emerged suggest that the training programme's approach to cultural competency is not as comprehensive as that in the literature. Cultural competency guidance bridges both technical and ethical domains. In relation to the above discrepancies guidance endorses gathering background knowledge (e.g. Cross et al., 1989) and suggests that the therapist should consider the impact of any intervention strategy on the client's continuous well-being in their environmental context (e.g. Lo & Fung, 2003). This raises an important question about if and how CBT training adopts the recommendations for culturally competent practice that the theoretical literature suggests.

Evidence-based practice can be defined as "the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences" (APA, 2006, p. 271). However, cultural competency as it relates to the characteristics and aptitudes of the practitioner is currently predominantly theory driven (Sue, Zane et al., 2009). Some of the tensions evident in the current study are also reflected in criticisms of cultural competency theory. For example, Hwang (2006) and Weinrach and Thomas (2002; 2004) argue that attempts to build knowledge about a given cultural group serves to ascribe typical characteristics and behaviours to group members and is inadvertently prejudicial, stereotypic, and fails to attend to the client's individuality. However, Sue (2003) argues that theory-driven research should continue as a valid strand that informs cultural competency practice and policy guidelines whilst the evidence accumulates.

If IAPT CBT training is to incorporate cultural competency in a more explicit and directive way this would involve a shift away from a predominantly evidence-based approach towards a more theoretically driven model of what constitutes competency. An acceptable alternative might be to incorporate more cultural competency guidance into the training programme, but not be prescriptive about how therapists practice. Exercises to explore what

cultural competency means to CBT would inform professional practice but allow therapists to exercise clinical judgement about application.

6.3 Research limitations

The current study aimed to investigate how guidance on cultural competency practice compares to the practice of CBT therapists and how training contributes to their work with BME clients. A qualitative approach was adopted to achieve these aims. Conclusions drawn from the study are based on a small sample and are therefore indicative but not necessarily generalizable to all CBT therapists. A quantitative methodology to follow this strand of research might substantiate the findings.

The participant sample was made up of individuals who had a relatively large amount of experience of working in mental health (see Appendix 2). Many attributed their competency to experience of working with diverse clients. Therefore it is difficult to make assertions about how the IAPT training might impact on the cultural competency of emergent therapists with less mental health experience prior to training.

The method adopted explored the views and experiences of therapists in relation to working with cultural issues in therapy. However, it is acknowledged that the assertions made by participants were subjective reflections on their own practice, rather than objective measurements of actual practice. Conclusions drawn from assumptions about the cultural competency of participating therapists are therefore tentative.

6.4 Recommendations for future research

Disagreements evident in the views of therapists, as well as in the literature, support a case for further research into cultural competency as it relates to the aptitudes of therapists. Some research has been conducted in the UK on how to tailor CBT treatment for specific BME groups (e.g. Rathod et al., 2010). However research also needs to address whether

cultural competency guidance relating to awareness, knowledge and skills improves the take-up of psychological therapies by BME communities, and whether it improves outcomes.

Specifically in the case of CBT, further research to substantiate the findings in the current study is warranted. Cultural competency of CBT therapists could be investigated in larger scale studies adopting different methodological approaches (e.g. quantitative). Such research will serve to establish whether cultural competency as described by contemporary literature theory improves the capacity of CBT therapists to work effectively with BME clients.

Findings suggest that the approach to engendering cultural competency through training of therapists may also benefit from research to gauge its effectiveness. Therapists working in diverse communities could be surveyed to evaluate whether training was effectively informing their practice. Also, a training programme that incorporates a revised format for its cultural competency component could be piloted. Training on cultural competency might be based on the comprehensive guidance available from the literature, and adopt the exercises suggested as useful in the current study. Again, the training component could be assessed for its impact on therapist competency and outcomes for BME clients.

6.5 Conclusions

The findings suggest that it is possible for therapists to work in a culturally sensitive way with BME clients without a comprehensive training component that is informed in detail by the cultural competency practice guidance available in the literature. Mental health experience acquired in a diverse community and a personal motivation to learn about cultural issues appear to be key contributors to cultural competency. They engender a level of awareness, knowledge and skills that facilitates culturally sensitive practice, and may be equally if not more valuable than an exposure to the cultural competency guidance during training.

A key barrier to the capacity of therapists to work in a culturally sensitive way relates to acknowledgment at a service level that sensitively conducting CBT requires flexibility in the amount of time allowed to complete an intervention. Communication, exploration of cultural issues, and adaptation to intervention approach are all factors that may require more attention when conducting CBT with BME clients.

It was not possible to ascertain from the current study whether a change to the training and competency requirements is necessary to develop competent therapists. However, the training programmes might improve their capacity to generate cultural competency by introducing learning exercises that stimulate refection on cultural issues, and by attending to the need for trainees to be able to discuss cultural influences in supervision.

7. Critical Appraisal

7.1 Selecting the research topic

My motivation to research the area of cultural competency was fuelled by a personal interest in how psychological practice is a culturally bound phenomenon. This interest was developed over the course of my clinical training and prior mental health work. I found myself quite challenged by the task of trying to explain key psychological concepts to members of my family and BME clients I had worked with previously in an IAPT service. I was aware after doing a philosophy degree that constructions of reality are very much dependent on the environmental context, and the differences in worldviews between my family's originating culture and those of Western society became progressively apparent. To find that psychological therapies were under-utilised by BME groups led me to question whether many of the treatment approaches in mental health were equally accessible to the BME population. I tended to read around the area of culture and I came to take the position that ethnicity was a factor that deserved special attention in mental health. This was reinforced by my perception that cultural issues (especially ethnicity) were acknowledged in

clinical training but also ‘skirted around’. Clinical examples of how culture was considered in research and practice were rare.

I came across the concept of cultural competency early in training. There was a wealth of US literature yet very little consideration of the topic in the UK My initial perception was that a great deal of work needed to be done to ensure psychological practices were sensitive to the needs of BME groups. I was particularly interested in how cultural competency could inform therapeutic practice. Whilst formulating ideas for a research area I engaged in several discussions with peers about how culture should be considered in psychological interventions. There was a lot of difference of opinion. Many believed that psychological practice involved being able to work with difference on a variety of levels, and ethnicity was just one thing that could be accommodated by good therapeutic practice without necessarily knowing about specific cultural differences. Another argument was that common human experiences and values should be the focus of intervention. The latter did not resonate with me because of my awareness of the fundamental ways in which ethnocultural factors influence worldview. The former position (that good therapy can be effective without cultural knowledge) was one that I became more open to later in the course of the research, especially after conducting the study. The reasons why will become apparent later in the section.

Initially I believed that cultural competency was something that was best achieved by viewing it as an explicit process or framework that could produce guidelines for practitioners on how to adapt therapy for a range of BME groups. However, my attendance at various conferences that took this principle too far led me to move away from the approach. Several researchers do take the approach that specific guidance on how to modify interventions such as CBT for specific groups should be produced (e.g Rathod et al., 2010). I found the theoretical positions to be flawed. To begin with a therapy thats creation and evidence-base is inextricable from Western roots is not in my view a good place to start. The implicit

philosopical orientations and values may be at odds with those of persons of a cultural make-up that is influenced by non-Western heritage. Also to try to base any approach on a *group* and assume some degree of homogeneity introduces technical and ethical dilemmas. It was not necessarily my view that such approaches might not work with some people, but I came (over the course of my reading) to consider that to focus on the characteristics and aptitudes of the practitioner was an ethically 'safer' way to generate cultural sensitivity in psychological practice.

Even cultural competency that focuses on the practitioner is arguably quite objective in some of the literature. A great deal of emphasis is placed on knowledge, especially knowledge of cultural group characteristics, although critical awareness of oneself and what brings to any human encounter is also emhasised. I was wary of the limitations of approaches that rely on this form of generalisation. However, I was also aware that psychological interventions incorporate lots of existential assumptions about people that are rooted in Western philosophies and worldviews, e.g. psychosocial development, concepts of self. To impose these on an individual who is unable to engage with them is, according to Kakkar (1996) a fruitless endeavour. This led me to question whether it was ethical for institutions and disciplines involved in the provision of mental health care not to develop practice based on knowledge of the worldviews and values of at least the minority groups that have populated the UK for several decades. It was therefore a political position that drove me to want to explore the utility of cultural competency theory and conduct research in the area. Since I had worked in an IAPT service previously, and IAPT is a massive programme that aims to meet diverse needs, it seemed logical to examine cultural competency in the IAPT context. Furthermore I was acquainted with some IAPT CBT therapists who had undergone the training and reported nominal input on cultural influences in therapy.

7.2 Hopes at the outset of the research

By conducting the research I wanted to find out whether the IAPT and CBT paradigm was able to meet the needs of BME individuals. I realised that there are many variables which can render therapy inaccessible to any individual, but it may still have been possible that factors (such as specific philosophical orientations) could alienate whole groups of people, or at least a large proportion of a group, from benefiting from a service provision which was designed to alleviate the distress of the population at large. If this was the case, then I wanted to contribute something that at least attempts to steer the direction of research and practice. Cultural competency came across to me in my investigations as having a different momentum and direction in the US compared to the UK. The US literature felt like *directives* that were based on values endorsed by all sorts of institutions. In the US there is a National Center for Cultural Competence that advises organisations and policy-makers on how to ensure cultural sensitivity is promoted. In the UK it felt like a strong value base that was intended to permeate all aspects of service provision, but in a less directive way, allowing institutions to formulate their own ideas about how cultural sensitivity is achieved. My research was, in part, fuelled by a need to explore whether a more explicit and directive approach to the training of CBT therapists was necessary.

7.3 Relationship to the topic

I was very conscious of my ethnic identity throughout the research. In the idea generation stage I needed to discuss the topic with various people and found myself moderating my views so as to not project myself as sort of social activist. On reflection I think this was an unconscious attempt to achieve impartiality, to be a scientist, to be objective. If asked explicitly whether this was possible I would have responded

negatively. A part of me may have been embarrassed about the topic I selected, perhaps because selecting it suggested that I chose it because I can take a position of being expert in culture because I belong to a BME group. Whilst conducting the actual focus groups I felt more at ease, although there were moments when it felt like I would have all the answers to the issues participants had raised in the discussion. This may have also been related to my position as a researcher, and being perceived as someone who was knowledgeable about the topic.

During the analysis my relationship to the topic became increasingly apparent. It would have been difficult to find an interpretation that was not in some way shaped to my experience of engaging the research subject and of conducting the research. At times I questioned the utility of qualitative analysis because it overwhelmingly felt that everything I saw or picked out was influenced by my perspectives on the general subject. By the end of the write up however I was reassured that subjectivity is a key strength of qualitative approaches.

7.4 Researcher subjectivity

To be able to reflect on what one brings to a piece of research is I believe essential to all methodologies, both quantitative and qualitative. The research process highlighted this. To be able to see that my subjectivity permeated the whole process and to eventually be able to acknowledge it and utilise it, rather than resist it, was liberating. Further reassurance and confidence in the findings came from seeing congruence between what I was left feeling after the focus groups and what the analysis suggested. The focus groups left me feeling encouraged about the intuition of therapists that develops over time. There was a sense of (me) being ‘looked after’ and of being ‘understood’ in the transference. My general feeling was that I had met a group of individuals that were intuitively

sensitive to and able to work with cultural influences in therapeutic encounters. The findings indicated the same and this congruence increased my confidence in the methodology and my ability to undertake it.

7.5 Reporting the research

Writing up the study made me feel that the conventions of report writing are not well suited to these types of analyses. There is a strong focus on structure and method that seems to acknowledge a researcher's experience of conducting the research, but needs to place it in the 'boot' of the report vehicle. I have not had opportunity to read a great many qualitative studies and am therefore unfamiliar with alternative formats, but I believe that reflexivity would be more useful if the writer was able to present it throughout an article.

The opportunity to appraise the study in a reflective way, as done in this section, was I believe useful to my learning from the research experience. Structured report writing is useful for dissemination. However, to be able demonstrate how reflexivity has influenced the researcher and the research in a less formal manner was itself a valuable exercise that enabled me to critically reflect on what I had learned throughout the research. The reflexive approach to the research project and the writing of this appraisal was taken from questions suggested by Willig (2001) to encourage a reflexive approach to research.

7.6 Impact of the research

On a personal level the research has significantly altered my understanding about how cultural sensitivity in clinical practice might be achieved. I have come to take the position that reflective discussions and the experience of trying to understand another individual (client or non-client) by exploring culture is equally important to cultural sensitivity as is prescriptive guidance. This position was strengthened by the experience of engaging in reflective discussion with participants, and also by the findings emergent from the study which suggested that cultural sensitivity was achieved through flexible application of generic therapeutic competencies.

Reflective discussions conducted and recorded with participants after the main interview was completed suggested that they valued the opportunity to discuss how culture influences their therapeutic practice. Group discussion appeared to generate debate about different perspectives on culturally sensitive practice. The process was viewed as one that facilitated learning, and that should be replicated in training and in peer supervision to facilitate continuous personal and professional development.

The findings do not devalue cultural competency guidance. Guidance is based on sound theoretical principles and strong values relating to equitable service provision (see Sue, Zane et al., 2009). However, it appears possible achieve cultural competency by working to the values that underpin health practices. It would be premature to recommend a comprehensive revision to CBT training or competencies on the basis of the current research. More research is required as outlined in the Discussion. However, I hope that the suggestions by CBT therapists on how to nurture cultural competency during training are considered by the relevant training institutions.

8. References

Alberta, A., & Wood, A. (2009). A practical skills model for effectively engaging clients in multicultural settings. *The Counseling Psychologist, 37* (4), 564-579.

American Psychological Association. (1993). *Guidelines for providers of services to ethnic, linguistic and culturally diverse populations.* Washington DC: Author.

American Psychological Association. (2002). *Guidelines on multicultural education, training, research, practice, and organizational change for psychologists.* Washington DC: Author.

American Psychological Association. (2003). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58* (5), 377-402.

Bassey, S. (2011). *Culturally competent practitioners in mental health: A review of the requirements*. Unpublished doctoral dissertation, University of Leicester, Leicester.

Beach, M., Price, E., Gary, T., Robinson, K., Gozu, A., Palacio A., . . . Cooper, L. (2005). Cultural competence: a systematic review of health care provider educational interventions. *Medical Care, 43* (4), 356-373.

Bennett, J., Kalathil, J., & Keating, F. (2007). *Race equality training in mental health services in england. does one size fit all?* London: Sainsbury Centre for Mental Health.

Bernal, G., & Scharron-Del-Rio, M. (2001). Are empirically supported treatments valid for ethnic minorities? Toward an alternative approach for treatment research. *Cultural Diversity and Ethnic Minority Psychology, 7* (4), 328-342.

Berry, J. (1980). Introduction to methodology. In H. Triandis, & J. Berry (Eds.), *Handbook of cross-cultural psychology: Vol. 2. Methodology*. (pp. 1-28). Boston: Allyn & Bacon.

Berry, J., & Kim, U. (1988). Acculturation and mental health. In P. Dasen, J. Berry, & N. Sartorius (Eds.), *Cross-cultural research and methodology series Vol. 10. Health and cross-cultural psychology: Towards applications.* (pp. 207-236). Thousand Oaks, CA: Sage.

Berry, J., & Sam, D. (1996). Acculturation and adaptation. In J. Berry, & M. Segall (Eds.), *Handbook of cross-cultural psychology. Volume 3. Social behavior and applications.* (pp. 291-325). Boston: Allyn & Bacon.

Bhui, K., & Bhugra, D. (2007). Ethnic inequalities and cultural capability framework in mental healthcare. In K. Bhui, & D. Bhugra (Eds.), *Textbook of cultural psychiatry.* (pp. 81-92). Cambridge: Cambridge University Press.

Bhui, K., & Singh, S. (2004). Cultural psychiatry research for the next decade. *Journal of Mental Health, 13* (2), 125-127.

Blackwell, D. (2005). *Counselling and Psychotherapy with Refugees.* London: Jessica Kingsley Publishers.

Burman, E. (1994). Interviewing. In P. Bannister, I. Parker, E. Burman, M. Taylor, & C. Tindall (Eds.), *Qualitative Methods in Psychology.* (pp. 49-71). London: Open University Press.

Campinha-Bacote, J. (2002). The process of cultural competence in the delivery of healthcare services: a model of care. *Journal of Transcultural Nursing, 13*, 181-184.

Collins, S., & Arthur, N. (2007). A framework for enhancing multicultural counselling competence. *Canadian Journal of Counselling, 41* (1), 31-49.

Comas-Diaz, L. (1992, Spring). The future of psychotherapy with ethnic minorities. *Psychotherapy, 29* (1), pp. 88-94.

Comas-Diaz, L., & Jacobsen, F. (1991). Ethnocultural transference and countertransference in the therapuetic dyad. *American Journal of Orthopsychiatry, 61*, 392-402.

Cross, T., Brazen, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care.* Washington DC: Georgetown University Child Development Center.

Cross, W. (1995). The psychology of nigrescence: revising the Cross model. In J. Pontoretto, J. Casas, L. Suzuki, & C. Alexander (Eds.), *Handbook of Multicultural Counseling.* Thousand Oaks, CA: Sage.

Daniels, J., Roysircar, G., Abeles, N., & Boyd, C. (2004). Individual and cultural-diversity competency: Focus on the therapist. *Journal of Clinical Psychology, 60* (7), 755-770.

Department of Health. (2003). *Inside/Outside.* London: Department of Health.

Department of Health. (2005). *Delivering race equality in mental health care, an Action Plan for reform inside and outside services.* London: Department of Health.

Department of Health. (2006). *Single Equality Scheme 2006-2009.* London: Author.

Department of Health. (2008). *Improving access to psychological therapies.* London: Author.

Department of Health. (2009). *Delivering race equality in mental health care; A review.* London: Department of Health.

Eleftheriadou, Z. (2002). Transcultural counselling and psychotherapy: a philosophical framework. In S. Palmer (Ed.), *Multicultural counselling: a reader.* (pp. 31-39). London: Sage.

Fernando, S. (1991). *Mental health, race and culture.* London: Macmillan MIND.

Fuertes, J., Stracuzzi, T., Bennett, J., Scheinholtz, J**.,** Mislowack**,** A., Hersh, M., & Cheng, D. (2006). Therapist multicultural competency: a study of therapy dyads. *Psychotherapy: Theory, Research, Practice, Training, 43* (4), 480-490.

Gumperz, J., Jupp, T., & Roberts, C. (1981). *'Cross-talk' - The wider perspective.* . Middlesex: Industrial Language Training Laboratory.

Hall, E. (1976). *Beyond culture.* New York: Anchor Press/Doubleday.

Hall, G., Iwamasa, G., & Smith, J. (2003). Ethical principles of the psychology profession and ethnic minority issues. In W. O'Donohue, & K. Ferguson (Eds.), *Handbook of professional ethics for psychologists: issues, questions, and controversies.* (pp. 301-318). Thousand Oaks, CA: Sage.

Hays, P. (2001). *Addressing cultural complexities in practice: A framework for clinicians and counselors.* Washington DC: American Psychological Association.

Hope, R. (2004). *The ten essential shared capabilities – A framework for the whole of the mental health workforce.* London: NIMHE.

Hwang, W. (2006). The psychotherapy adaptation and modification framework: application to Asian Americans. *American Psychologist, 61* (7), 702-715.

Kakar, S. (1996). *The Indian psyche*. New Dehli: Oxford University Press

King. (1998). Template analysis. In C. Cassell, & G. Symon (Eds.), *Qualitative methods and analysis in organisatoinal research.* (pp. 118-134). London: Sage.

King, N. (2004). Template analysis. Retrieved 21 May 2009 from the Template Analysis Web site: http://www.hud.ac.uk/hhs/research/template_analysis/ whatis.htm

Krause, I. (1989). Sinking heart: A Punjabi communication of distress. *Social Science and Medicine, 29* (4), 563-575.

Lago, C. (2006). *Race, Culture and Counselling: The Ongoing Challenge.* (2nd ed.). Maidenhead: Open University Press.

Laungani, P. (1997). Replacing client-centred counselling with culture-centred counselling. *Counselling Psychology Quarterly, 10* (4), 343-351.

Lee, C. (2006). Updating the models of identity development. In C. Lago (Ed.), *Race, Culture and Counselling. The ongoing challenge.* (pp. 179-186). Maidenhead: Open University Press.

Leong, F. (1997). Cross-cultural career psychology: Comment on Fouad, Harmon, and Borgen (1997) and Tracey, Watanabe, and Schneider (1997). *Journal of Counselling Psychology, 44*, 355-359.

Lo, H., & Fung, K. (2003). Culturally competent psychotherapy. *Canadian Journal of Psychiatry, 48* (3), 161-170.

Lopez, S. (1997). Cultural competence in psychotherapy: A guide for clinicians and their supervisors. In C. Watkins (Ed.), *Handbook of psychotherapy supervision.* (pp. 570-588). New York: Wiley.

Lopez, S. (2006). Cultural competence and psychotherapy: Applying anthropologically informed conceptions of culture. *Psychotherapy: Theory, Research, Practice, Training, 43* (4), 380-396.

Macdougall, C., & Arthur, N. (2001). Applying Racial Identity Models in Multicultural Counselling. *Canadian Journal of Counselling, 35* (2), 122-136.

Nadirshaw, Z. (2009). Race, culture and ethnicity in mental health care. In R. Newall, & K. Gournay, *Mental Health Nursing: An Evidence Based Approach.* (2nd ed., pp. 39-55). London: Churchill Livingstone.

National Institute for Health and Clinical Excellence. [NICE]. (2005a). The management of PTSD in adults and children in primary and secondary care. Retrieved July 17, 2011, from NICE Guidance Web site:
http://guidance.nice.org.uk/nicemedia/live/10966/29769/29769.pdf

National Institute for Health and Clinical Excellence. [NICE]. (2005b). Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder. Retrieved July 17, 2011, from NICE Guidance Web site:
http://guidance.nice.org.uk/nicemedia/live/10976/29947/29947.pdf

National Institute for Health and Clinical Excellence. [NICE]. (2009). The NICE guideline on the treatment and management of depression in adults. Retrieved July 17, 2011, from NICE Guidance Web site:
http://guidance.nice.org.uk/nicemedia/live/12329/45896/45896.pdf

National Institute for Health and Clinical Excellence. [NICE]. (2011). Generalised anxiety disorder and panic disorder (with or
without agoraphobia) in adults. Management in primary, secondary and

community care. Retrieved July 17, 2011, from NICE Guidance Web site: http://guidance.nice.org.uk/nicemedia/live/13314/52599/52599.pdf

Patel, N., Bennett, E., Dennis, M., Dosanjh, N., Mahtani, A., Miller, A., & Nadirshaw, Z. (2000). *Clinical Psychology. Race and Culture: a training manual.* Leicester: British Psychological Society.

Patterson, C. (2004). Do we need multicultural counseling competencies? *Journal of Mental Healh Counseling, 26* (1), 67-73.

Pedersen, P. (1991). Multiculturalism as a generic approach to counseling. *Journal of Counseling and Development, 70,* 6-12.

Pedersen, P. (2001). Multiculturalism and the paradigm shift in counselling. Controversies and alternative futures. *Canadian Journal of Counselling, 35* (1), 15-25.

Pedersen, P. (1995). The culture-bound counsellor as an unintentional racist. *Canadian Journal of Counselling, 29,* 197-205.

Ponterotto, J., & Pedersen, P. (1993). *Preventing prejudice.* Newbury Park, CA: Sage.

Rathod, S., Kingdon, D., Phiri, P., & Gobbi, M. (2010, July 15). Developing culturally sensitive cognitive behaviour therapy for psychosis for ethnic minority patients by exploration and incorporation of service users' and health professionals' views and opinions. *Behavioural and Cognitive Psychotherapy*, pp. 1-23.

Ridley, C. (1995). *Overcoming unintentional racism in counseling and therapy: A practitioner's guide to intentional intervention.* Thousand Oaks, CA: Sage.

Roland, A. (1988). *In search of the self in India and Japan: Toward a cross-cultural psychology.* Guildford: Princeton University Press.

Schilling, B., & Brannon, E. (1986). In E. Randall-David (Ed.), *Strategies for workng with culturally diverse communities and clients.* Washington DC: Association for the Care of Children's Health.

Seale, C., Gobo, G., Gubrium, J., & Silverman, D. (2004). *Qualitative research practice.* London: Sage.

St. Clair, A., & McKenry, L. (1999). Preparing culturally competent practitioners. *Journal of Nursing Education, 38* (5), 228-234.

Stuart, R. (2004). Twelve practical suggestions for achieving multicultural competence. *Professional Psychology: Research and Practice, 35* (1), 3-9.

Sue, D. (2001). Multidimensional facets of cultural competence. *The Counseling Psychologist, 29* (6), 790-821.

Sue, D., Arredondo, P., & McDavis, R. (1992, March/April). Multicultural counseling competencies and Standards: A call to the profession. *Journal of Counseling and Development*, pp. 477-486.

Sue, D., & Sue, D. (1999). *Counselling the culturally different. theory and practice.* (3rd ed.). New York: Wiley.

Sue, D., & Torino, G. (2005). Racial-cultural competence: Awareness, knowledge, and skills. In R. Carter (Ed.), *Handbook of racial-cultural psychology and couseling: Vol. 2. Training and Practice.* (pp. 3-18). Hoboken, NJ: Wiley.

Sue, S. (1998). In search of cultural competence in psychotherapy and counselling. *American Psychologist, 53* (4), 440-448.

Sue, S. (2003). In defense of cultural competency in psychotherapy and treatment. *American Psychologist, 58* (11), 964-970.

Sue, S., & Zane, N. (1987). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *American Psychologist, 42* (1), 37-45.

Sue, S., Zane, N., Hall, G., & Berger, L. (2009). The case for cultural competency in psychotherapeutic interventions. *Annual Review of Psychology, 60*, 525-548.

Toporek, R., & Reza, J. (2001). Context as a critical dimension of multicultural counseling: Articulating personal. professional, and institutional competence. *Journal of Multicultural Counseling and Development, 49*, 13-31.

Tribe, R., & Raval, H. (2003). *Workng with interpreters in mental health.* London: Brunner-Routledge.

Tseng, W. (2004). Culture and psychotherapy: Asian perspectives. *Journal of Mental Health, 13* (2), 151-161.

Warren, B. (2000). Cultural Competence: A best practice process for psychiatric-mental health nursing. *Journal of the American Psychiatric Nurses Association, 6* (4), 135-138.

Webb Johnson, A. (1993, March 9). Cultural Divide. *Counselling News*, pp. 26-27.

Weinrach, S., & Thomas, K. (2002). A critical analysis of the multicultural counseling competencies: implications for the practice of mental health counseling. *Journal of Mental Health Counseling, 24* (1), 20-35.

Weinrach, S., & Thomas, K. (2004). The AMCD multicultural counseling competencies: a critically flawed initiative. *Journal of Mental Health Counseling, 26*, 81-93.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method.* Buckingham: Open University Press.

Appendix 1

Clinical Psychology Dept.
104 Regent Road
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F: 0116 223 1650

Participation Information Sheet

1. Study Title

'An Investigation of Cultural Competence in the Experiences of Therapists Newly Trained to Deliver Cognitive-Behavioural Therapy'.

Ethics Number: 10/H0408/29

Researcher: Suki Bassey, Clinical Psychologist Trainee, University of Leicester

Contact: E. sukibassey@live.co.uk / sb409@le.ac.uk, T. [redacted]

2. Invitation to participate

As an IAPT therapist who has completed at least one session of CBT with a BME patient, you are being asked to agree to take part in this study. The following information will explain why the research is being done and will help you to decide whether you want to take part. If you have any further questions after reading this document, please feel free to contact the researcher. You may also wish to discuss it with your line manager, who will be aware of the research and has agreed for you to take part.

3. What is the purpose of the study?

There is much research into the influence that patients' cultural background may potentially have in therapeutic engagement. Perspectives vary on the extent to which cultural background is relevant according to the mode of therapy employed. Consequently the approach to training of therapists is shaped by such perspectives. This study explores the views and experiences of IAPT therapists doing CBT with BME patients, and their views on whether IAPT training to deliver culturally sensitive CBT is appropriate.

4. What will you be asked about?

You will be asked about your experiences of doing CBT with patients from BME groups, your views on modifying practice, and if and how you believe your IAPT training has influenced your practice.

5. What will this entail?

This will be done by means of a group discussion with 2 to 6 of your therapist colleagues from the same service as you. Questions will be introduced by the researcher. The group interview will last 90 minutes with a midway 10 minute break. With 10 minutes for pre-session instructions and 10 minutes for a post-session debrief, the entire session will last up to 2 hours. Your service has agreed for you to take part in this study during work hours.

You will not have to engage in discussion or answer questions about topics you do not wish to talk about.

The interviews will be audio recorded and transcribed (by the researcher) for analysis. The recordings will be stored on an encrypted memory stick and held securely at the Clinical Psychology Department of University of Leicester. Once the recordings have been transcribed they will be returned to you for verification. After you have checked the transcripts and returned

them to the researcher, the recordings will be permanently deleted.

6. Confidentiality and Anonymity

Your comments will not be unduly shared with anyone outside of the focus group or individual interview in a non-anonymised form. Transcription of interviews will be produced in a completely anonymous format, removing any participant names, references to places etc. Anonymous extracts from interviews may be incorporated into the final publication.

7. What will happen if I agree to take part?

If you agree to take part you can contact the researcher directly and they will give you details of when the interview session will take place. The researcher will liaise with your line manager to schedule the session. Further instructions and the opportunity to ask questions will be scheduled in the actual session. You will be asked to sign a consent form before the interview.

If you choose to participate, you retain the right to withdraw up to when data is anonymised.

8. Are there any risks in taking part?

No significant risks have been identified in this study. If, however, you get distressed during the process, the researcher will be prepared to take action to make sure you are cared for.

9. What are the potential benefits in taking part?

To participate in this study is an opportunity to potentially influence the way IAPT therapists are trained, and ultimately to contribute to a better mental health service provision for everyone accessing IAPT services, especially BME populations. You may also benefit by reflection on the topics discussed and the practices of your colleagues, which in turn may influence your practice.

10. How will the findings of the study be used?

A report will be disseminated to the relevant training bodies, IAPT service leads across the [redacted], and [redacted] Team. They may be presented at conferences. The study will be submitted for publication to selected journals in Autumn 2012. You will not be identifiable in any of the proceeds. A copy of the final report will be available from the researcher in Autumn 2011 if you request it.

11. Who is funding the research?

The research is being funded by the University of Leicester and is sponsored by Leicestershire Partnership Trust.

12. Who has reviewed the study?

The research has been reviewed and approved by the Nottingham Research Ethics Proportionate Review Sub-Committee and [redacted] Research & Development.

13. Further Information

If you require any more information now or in the future you may contact the researcher Suki Bassey (T: [redacted] / E: sukibassey@live.co.uk / sb409@le.ac.uk).

THANK YOU FOR TAKING THE TIME TO CONSIDER PARTICIPATING.

Clinical Psychology Dept.
University of Leicester
104 Regent Road
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LE1 7LT

T: 0116 223 1639
F: 0116 223 1650

Date:

Dear

Re: Research Opportunity

An Investigation of Cultural Competence in the Experiences of Therapists Newly Trained to Deliver Cognitive-Behavioural Therapy.

I am conducting research into the experiences of newly trained Cognitive-Behavioural Therapists, under IAPT services, in relation their perceptions of working in a culturally sensitive way and how training has influenced their work.

Your involvement in the research, should you agree to take part, will be to take part in a focus group with fellow therapists from your service lasting 2 hours. Alternatively you may be invited to a one to one interview for 90 minutes. I will ask you questions about your experiences of training, and your views on working with patients from BME groups.

Please read the enclosed Information Sheet which provides further details. I will be in contact with you shortly to find out what you have decided about whether you would like to take part or not; and if you are happy to go ahead, to arrange a suitable time for the group.

Participation is entirely voluntary, and you will be able to withdraw from the study at any time if you change your mind without having to give an explanation.

Thank you.

Yours sincerely

Suki Bassey
School of Psychology – Clinical Section
University of Leicester
104 Regent Road
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LE1 7LT
Email: sb409@le.ac.uk

Appendix 2

Participant Characteristics

Participant	Age	Sex	Ethnicity	Health Experience	Mental Health Experience	CBT Training completion	Training in other modalities
1	48	M	Asian Indian	21	21	2010	-
2	54	M	White British	29	27	2010	Cognitive Analytic Therapy
3	39	F	Asian Indian	18	15	2010	Interpersonal Therapy
4	35	F	White, Other	11	11	2010	Counselling
5	51	F	White British	25	15	2010	Psychodynamic/ Integrative
6	38	F	White, Other	11	11	2010	Solution Focused Therapy/ Counselling
7	48	F	Asian Indian	15	15	2010	Person-centred Counselling/ Psychodynamic
8	29	F	White British	7	5	2009	-
9	35	M	White British	15	15	2009	-
10	38	M	White British	6	6	2009	-

Ethnicity classification from the Department of Health national standard based on the 2001 Census.

Appendix 3

Interview Schedule

Stage One: For the first half of the session we are going to focus on your views and practices in relation to doing CBT with BME patients. In the second stage we will consider skills and knowledge you draw on in therapy and the influence of your training programme.

1) **Views on doing CBT with BME patients.**
   There is a view in doing therapy a therapist needs to take account of a patient's culture, and modify the intervention accordingly. Ethnicity is one cultural aspect that may warrant modification to therapy.

   a) Let's start with a general question. Do you think that there is a need for a therapist to modify CBT in any way when working with a patient of BME background?
      i) If not, then why not?
      ii) If yes, what needs to be modified?
      iii) Why does ..... need to be modified?
      iv) What sort of modifications do you make?
      v) What are some of the difficulties in doing this?

      Do others share this view? What would others say? How have you concluded such?

2) **Modification of CBT**
   CBT involves a range of stages and features including: 'assessment', 'formulation and treatment planning', 'engagement', 'explaining CBT rationale', 'fostering and maintaining a therapeutic alliance', 'collaboration', 'agreeing goals', 'session structure and pace', 'homework', 'monitoring', and 'ending'.

   a) Do you feel that any of these components specifically need to be modified on the basis of cultural background? Which ones?
   b) Let's take those one at a time. In ..... what might you do differently?
   c) What were some of the difficulties faced?
   d) What was helpful?
   e) How would you explain this?
      Would others agree? Has anyone else experienced this? What have others done?

Stage Two: Now we are going to look at the skills required to do CBT in a culturally sensitive way and the influence of your training.

3) Competency of therapists.

IAPT recognises the need for 'cultural competence', or the ability to work with individuals from a diverse range of backgrounds. It assumes that you will be able to draw on competency you generally have as a health professional and learn to do CBT in a culturally sensitive way. In this part of the interview we want to get your perspectives on this approach.

a) From where would you say your knowledge and skills in working in a culturally sensitive way have come from?

   What would others say? How has what you stated shaped your practice?

b) Do feel confident to do CBT with people from any/all BME groups?
   i) Why is this the case?

   Does anyone else feel the same/differently? Why? What would help?

c) Do you think that it is important to know anything about the cultural background of the patient beforehand?
   i) What would you want to know?
   ii) Why would this be useful to you?
   iii) Can you relate any examples of this being the case?

   What do others think about this? Why?

4) IAPT training

a) In what aspects of therapy with BME patients has training helped, if at all?

Do others share these views? Why has ..... been helpful?

b) What sort of training is most helpful? Lectures, supervision, case work, other?

Why is ..... helpful? How has it helped you?

c) What do think the training could incorporate to help?
   i) How might this be done?

END

Appendix 4

Clinical Psychology Dept.
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T: 0116 223 1639
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Ethics Number: 10/H0408/29
Participant Identification Number:…..

CONSENT FORM

Title of Project: 'An Investigation of Cultural Competence in the Experiences of Therapists Newly Trained to Deliver Cognitive-Behavioural Therapy'.

Name of Researcher: Suki Bassey, Clinical Psychologist Trainee, University of Leicester

Thank you for agreeing to take part in this research project. Please read this consent form, and ask any further questions you would like to about what will be involved.

Please initial box

1. I confirm that I have read and understand the information sheet dated 10/01/2010 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐
3. I understand that I will be interviewed, and that the interview will be audio recorded, and then transcribed. ☐
4. I understand that my identity will remain anonymous throughout the study and that if quotations are used from my interview, that my identity and the identities of other people I may mention will also be anonymised. ☐
5. I understand that if the interviewer is concerned about my safety or the safety of anyone that I might mention during the interview, that the interviewer has a duty to break confidentiality. ☐
6. I understand that data from the interview will be kept securely at the University of Leicester, and destroyed after one year. ☐
7. I understand that my interview will be included as part of a Doctoral thesis, and that results will be published in academic journals and fed back to Participants. ☐
8. **I agree to take part in this study.**

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

The following anonymous information will not be reported, but used only to reflect on by the researcher during the analysis of material.

What is your age?		
What is your gender?		
What is your ethnicity? (List is the Department of Health national standard based on the 2001 Census.)	**White** □ British □ Irish □ Any other White background **Mixed** □ White and Black Caribbean □ White and Black African □ White and Asian □ Any other mixed background **Asian or Asian British** □ Indian □ Pakistani □ Bangladeshi □ Any other Asian background	**Black or Black British** □ Caribbean □ African □ Any other Black background **Other ethnic categories** □ Chinese □ Any other ethnic category **Not stated** □ Not stated Any other background (specify) .....
How long have you been doing healthcare work (any type) that involves direct contact with clients?		
How long have you been doing direct contact work in mental health?		
When did you complete your training in CBT?		
Where was this done?		
Do you have any other qualifications or experience in different approaches/treatment models? If so, what are they?		

Thank you.

Appendix 5

Epistemological Position

The proposed research was conducted from the epistemological position that it is possible to locate the experiences and views of participating therapists within a theoretical framework for practitioner cultural competence (taken from contemporary literature). The philosophical position taken is therefore essentially 'realist', i.e. cultural competency exists and can be found or not found in the practices of CBT therapists. It was therefore considered possible to attribute successful or difficult experiences of therapists broadly to application or non-application of established cultural competencies, and accordingly to ascertain what is productive or counter-productive in the context of training and practice of CBT under IAPT.

Appendix 6

Example showing the development (across initial, intermediate and final templates) of the theme of 'Incorporating appropriate strategies and goals' and its sub-themes. References to transcript is shown as (Transc. #) Line # - Line #

Initial Template

Level 2	Level 3	Level 4
Incorporating appropriate strategies/goals	Consistent with the orientation/abilities of the client (2)4551-460 (2)570-578 (2)644-663	Modifying structure, content and pace according to the needs of the client (2)413-427 (2)451-455 Experimentation in technique to fit with client (2)670-677 Pace and structure often need to be modified when communication is a barrier (2)484-509/515-527 Practitioners require institutional support to accommodate cultural needs (2)504-509 (2)1097-1111/1125-1130
	Alternative views of 'normality'	Goals not consistent with measures (2)600-609
	Establishing expectations of therapy	Explaining the therapy and evaluating appropriateness with the client (offering other approaches) (2)367-380 (2)553-564 Allowing client to articulate aims (2)204-206 (2)750-752
	Identifying culturally related strengths and supports	
	Building skills to interact more effectively with the social/physical environment and minimise stress	
	Modifying approach to goal acquisition – balancing directiveness, respect	
	Question the helpfulness of thoughts/beliefs rather than their validity	
	Avoidance of challenging core beliefs	
	Create culturally congruent tasks/homework assignments	Necessarily need to relate to life so same for everyone (2)469-479

Intermediate Template

Level 2	Level 3	Level 4
Incorporating appropriate strategies/goals	Consistent with the orientation/abilities of the client	Modifying structure, content and pace according to the needs of the client (2)413-427/451-460/570-578/644-663 (3)201-211/223-226/230-242/261-289/311-327/357-369/394-399 (1)403-411/437-448/504-510/591-593/1320-1328 Pace and structure often need to be modified when communication is a barrier (2)484-509/515-527 (3)485-492 (1)1343-1355 Holding on to fundamentals of the approach e.g. formulation (3)486-496 (1)853-864 Necessarily need to relate tasks to life so same for everyone (2)469-479 (1)617-619 Experimentation in technique to fit with client (2)670-677 Challenge of translating tasks of therapy Pace and structure often need to be modified when communication is a barrier (2)484-509/515-527 (3)485-492/339-342 Practitioners require institutional support to accommodate cultural needs (2)504-509 (2)1097-1111/1125-1130 (1)1271-1289
	Accommodating alternative views of 'normality'	Goals not consistent with measures (2)600-609
	Establishing expectations of therapy (2)750-752 (1)920-928	Explaining the therapy and evaluating appropriateness with the client (offering other approaches) (2)367-380/553-564 (3)223-226/401-414/415-422/424-430 (1)34-40 Allowing client to articulate aims (2)204-206
	Identifying culturally related strengths and supports (1)1217-1221	
	Build skills to interact more effectively with the social/physical environment and minimise stress	
	Modifying approach to goal acquisition – balancing directiveness, respect (1)863-888	
	Question the helpfulness of thoughts/beliefs rather than their validity	
	Avoidance of challenging core beliefs (1)139-161/380-396/412-427/613-615	

Final Template

	Level 1 Themes		Level 2 Themes		Level 3 Themes
9.	Incorporating appropriate strategies/goals	9.1	Modifying structure, content and pace according to the needs of the client (2)413-427/451-460/570-578/644-663 (3)201-211/223-226/230-242/261-289/311-327/357-369/394-399 (1)403-411/437-448/504-510/591-593/1320-1328 (2)339-342 (3)201-211(3)486-496 (1)853-864(2)484-509/515-527 (3)485-492	9.1.1	Communication difficulties impact on structure and pace (2)484-509/515-527 (3)485-492 (1)1343-1355
				9.1.2	Practitioners require institutional support to accommodate cultural needs (2)504-509 (2)1097-1111/1125-1130 (1)1271-1289
				9.1.3	Accommodating alternative views of 'normality' (2)600-609
				9.1.4	Avoidance of challenging core beliefs (1)139-161/380-396/412-427/613-615
				9.1.5	Modifying approach to goal acquisition – balancing directiveness, respect (1)863-888
				9.1.6	Consistency of goals with measures (2)600-609
		9.2	Tailoring of strategies/goals not different on the basis of ethnicity (2)469-479 (1)617-619		

xii

Appendix 7

Research Chronology

Draft proposal submitted for Peer Review	-	Dec 2010
Revised proposal submitted to Research Ethics Committee and Research & Development departments	-	Mar 2010
REC approval	-	22nd March 2010
Site 1 approval	-	1st June 2010
Site 2 approval	-	13th Oct 2010
Site 3 approval	-	23rd May 2010
Participant recruitment	-	May thru Dec 2010
Focus group 1 conducted	-	14th Oct 2010
Focus group 2 conducted	-	16th Nov 2010
Focus group 3 conducted	-	27th Jan 2011
Transcription completed by	-	Feb 2011
Data analysis	-	March-April 2011
Thesis write up	-	April-May 2011
Hand in of thesis -	-	May 31st 2011
Examination of Thesis by Viva	-	July 4th 2011
Amendments	-	plus 1 month
Dissemination of report	-	Oct 2011
Editing for journal and submission	-	by Spring 2012

Appendix 8

Target Journal Guidelines

Ethnicity and Inequalities in Health and Social Care.
Guidelines for contributors.

About the Journal
Ethnicity and Inequalities in Health and Social Care promotes equality in health and social care, with a particular emphasis on race and ethnicity. A key area of interest is the relationship between ethnicity and other forms of inequality – what is often now referred to as intersectionality (Crenshaw, 1994).

The Journal's primary aims are to:
- provide evidence-rich information to enable managers and frontline practitioners to improve performance in relation to ethnicity and inequalities
- provoke reflection and support critical analysis of the challenges and strengths in this area.

Submission of papers
Articles will fall into one of the following categories.
- Think pieces – analysis of current policy or practice by people with a reputation in their field (up to 5,000 words in length)
- Project reports (up to 2,000 words in length)
- Reports, findings and recommendations arising from research (3,000–5,000 words in length)
- Referenced, evidence-based articles to help inform management or frontline practice (3,000–5,000 words in length).

Making a submission
Before submitting please ensure that your article includes the following:
- a **short summary/abstract (c. 250 words) and 5/6 key words** at the beginning
- a full mailing address and email **correspondence details for the main author**
- a bulleted list of the specific **implications for practice** of the article/research.

Please send submissions to the publishers:
Jo Sharrocks, Publishing Manager, Pier Professional
Suite N4, The Old Market, Upper Market Street, Hove BN3 1AS, UK
Tel: +44 (0)1273 783721; Email: **jos@pierprofessional.com**
Any queries about the subject matter of your article should be directed to one of the editors:
- **Margaret Greenfields**, Co-editor
Reader in Social Policy and Director of IDRICS (Institute for Diversity Research, Inclusivity,
Community and Society), Buckinghamshire New University, UK
Email: **Margaret.Greenfields@bucks.ac.uk**
- **Hári Sewell**, Co-editor
Independent Consultant and Former Executive Director in the NHS, UK
Email: **hari.sewell@hsconsultancy.org.uk**

Guidance on the formatting of papers:.
Please consult the following guidelines when preparing a paper for ***Ethnicity and Inequalities in Healthand Social Care.***
Content

Our aim in this journal is to establish a high quality source of information and intelligence for policymakers, practitioners, researchers and managers across a range of settings. **Our intention is to link theory to practice.** We aim to make the journal accessible, readable and challenging. When you write for us, therefore, please make sure that your work:

- is clear and free from jargon
- is non-sexist and anti-discriminatory on the basis of age, disability, sex, race and ethnicity, religion or belief (or lack of), sexual orientation gender reassignment (as per *The Equality Act 2010*)
- uses respectful language
- is rooted in current research
- is encouraging of reflection on attitudes and best practice.

Bullet points

It will greatly aid accessibility and ease of use if you make full use of bulleted lists in your article containing, for example:

- key points of a document
- practical steps worth highlighting
- relevant issues from recent legislation
- conclusions.

Illustrations

If appropriate, include original charts, graphs or diagrams to illustrate particular points as an aid to clarity and understanding. Diagrams and figures will be reproduced in accordance with the publisher's house style. This may mean that diagrams and figures are not always recreated exactly the same as the original, however, the meaning will not be altered in any way.

References

Please include all references in full at the end of your article, giving the **author, date, title of the book or title of the article/journal, the journal volume, page numbers, place of publication and publisher**.

In the text use we use the Harvard system: ie, refer to references by name and date in brackets; for example: (Smith, 1994) or (Emerson *et al*, 1992) with a comma between name and date. Where there is more than one reference by the same author, a, b or c should distinguish them: (Smith, 1994a). If you use referencing software (such as Endnote or Refworks) please ensure that the copy you submit has the formatting codes removed as these interfere with the publisher's software.

Examples:

Pickard J (1998) *Getting Older, Getting Wiser.* London: Pentonville Press.

Pickard J (1998) *Getting Older, Getting Wiser* (2nd edition). London: Pentonville Press.

Department of Health (1992) *Services for People with Learning Disabilities and Challenging Behaviour or Mental Health Needs*. London: HMSO.

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Appendix 9

Approval letters from:

Research Ethics Committee

Research and Development Departments at 3 sites

(on following pages)